IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

SPENCER L. DAVIS PLAINTIFF

VS. NO. 4:18-cv-341-DPM

AT&T UMBRELLA BENEFIT PLAN NO. 3 DEFENDANT

COMPLAINT

COMES NOW Plaintiff, Spencer L. Davis ("Davis"), by and through his attorney, Daniel A. Webb, and for his complaint states:

PARTIES AND JURISDICTION

1. This is an action to recover long term disability benefits pursuant to section 502(a), (e)(1) and (f) of the Employee Retirement Income Security Act of 1974 ("ERISA"). 29 U.S.C. § 1132(a), (e)(1) and (f).

2. This Court has federal question subject matter jurisdiction and personal jurisdiction over the parties and is the proper venue pursuant to 28 U.S.C. § 1391(b).

3. Plaintiff, Davis, is a resident of Saline County, Arkansas. Davis participated in the AT&T Umbrella Benefit Plan No. 3 (the "Plan") for employer provided long term disability benefits while employed by AT&T Inc. (See Plan attached as exhibit A)

4. The Plan offers long term disability benefits to AT&T Inc. employees under the AT&T Disability Income Program for Southwest Bargained Employees.

This case assigned to District Judge Marshall
and to Magistrate Judge Deere

5. The Plan is the proper Defendant to this cause of action. (See exhibit A pg. 28)

6. The Plan is sponsored by AT&T Inc.

7. AT&T Services, Inc. is the Plan Administrator, and Sedgwick is the Claims Administrator for the Plan.

FACTS

8. While employed by AT&T, Davis participated in the Plan. While a Plan participant, Davis developed lumbar disk disease with myelopathy, back pain, intervertebral disc degeneration, spondylosis, paresthesia left leg pain, lumbar stenosis and other debilitating health problems.

9. Davis' conditions, especially as relate to his spine, have rendered him totally and permanently disabled, and he suffers from severe physical limitations such that he is unable to perform even sedentary work on a sustained basis.

10. Initially, the Plan paid benefits to Davis, but on or about October 26, 2015; despite Davis' severe medical problems, the Plan, without legal justification, stopped paying benefits to Davis and continues to refuse to pay Davis the long-term disability benefits Davis is owed.

11. Davis has complied with all conditions precedent to entitle him to benefits under the Plan and to file this lawsuit.

12. Davis received a final denial from the Plan on or about February 19, 2016.

13. Davis was approved for Social Security disability and payments began April of 2015. An offset for benefits payable by the Plan may be applicable. (See Award letter attached Exhibit B)

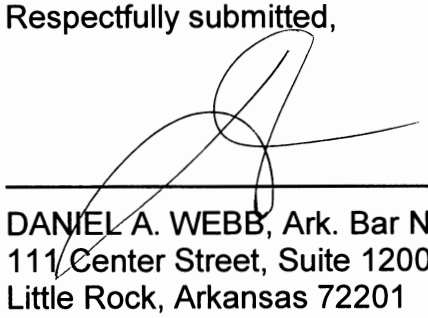
14. The Plan is controlled by AT&T Inc. and its subsidiaries who are the are the fiduciaries responsible for approving or denying claims and paying them if approved. Accordingly, the Plan maintains a conflict of interest in the present situation.

15. Davis has been forced to retain the services of counsel in order to bring this action, and the Plan is obligated to pay attorney fees in addition to the unpaid benefits owed Davis.

16. It is appropriate under these circumstances to award Davis pre-judgment interest in addition to awarding him back benefits and current benefits under the Plan.

WHEREFORE, Plaintiff prays for an order awarding him: back benefits, current benefits and future benefits pursuant to the Plan, pre-judgment interest, attorney's fees, costs and all other appropriate and proper relief.

Respectfully submitted,



DANIEL A. WEBB, Ark. Bar No. 2000113
111 Center Street, Suite 1200
Little Rock, Arkansas 72201
(501) 372-2400

EXHIBIT
A

Summary Plan Description

IMPORTANT BENEFITS INFORMATION

AT&T Disability Income Program for Southwest Bargained Employees

This is an updated summary plan description (SPD) for the AT&T Disability Income Program for Southwest Bargained Employees. This SPD replaces your existing SPD dated June 2009 and all of its summaries of material modifications (SMMs).

Please keep this SPD for future reference.

NIN: 78-31414

IMPORTANT INFORMATION

This summary plan description (SPD) along with the AT&T Umbrella Benefit Plan No. 3 (Plan) is the official document for the benefits offered under the AT&T Disability Income Program for Southwest Bargained Employees (Program). It will govern and be the final authority on the terms of the Program. AT&T reserves the right to terminate or amend any and all of its employee benefit plans or programs, at any time for any reason. Participation in this Program is neither a contract nor a guarantee of future employment.

What is this document?

This SPD, together with any summaries of material modifications (SMMs) issued for this Program, constitute your SPD for this Program.

Este documento contiene un resumen, en inglés. Si usted tiene dificultad en entender este documento, entre en contacto por favor con AT&T Integrated Disability Service Center, **866-276-2278**.

What action do I need to take?

You should review this SPD.

How do I use this document?

As you read this SPD, pay special attention to the key points at the beginning of most major sections and shaded boxes that contain helpful examples and important notes. While AT&T has provided these tools to help you better understand the Program, it is important that you read the SPD in its entirety, so that you can understand the Program details. Also, throughout this SPD, there are cross-references to other sections in the SPD. Please consult the Table of Contents to help you locate these cross-referenced sections.

Keep your SPDs and SMMs for you future reference. They are your primary resource for your questions about the Program.

Questions?

If you have questions regarding your Program benefits, contact the Claims Administrator. See the "Contact Information" section for information on how to contact the Claims Administrator.

Si usted tiene alguna dificultad en entender cualquier parte de este documento, entre en contacto por favor con el Claims Administrator en la seccion de "Contact Information".

USING THIS SUMMARY PLAN DESCRIPTION

KEY POINTS

- *This SPD applies to you if you become Partially or Totally Disabled on or after Jan. 1, 2014.*
- *If you were Disabled before Jan. 1, 2014 and continue to be Disabled on and after Jan. 1, 2014, the determination as to whether you are eligible for benefits under the Program, whether you are Disabled, and the amount and duration of your benefits are determined by the plan provisions that were in effect when you became Disabled. For all other purposes (such as the contact information and the claim and appeal process), the provisions of this SPD are applicable to you beginning Jan. 1, 2014.*

This SPD is a legal document that provides comprehensive information about the AT&T Disability Income Program for Southwest Bargained Employees (Program).

This document describes the disability and Vocational Rehabilitation Benefits offered to those employees eligible to receive benefits from the Program and is intended to serve as the SPD as required by the Employee Retirement Income Security Act of 1974 (ERISA).

Use this SPD to find answers to your questions about your Program benefits in effect as of Jan. 1, 2014. This SPD replaces all previously issued SPDs and SMMs and applies to you if you become Partially or Totally Disabled on or after Jan. 1, 2014. If you became Partially or Totally Disabled before Jan. 1, 2014, and continue to be Disabled on and after Jan. 1, 2014, the determination as to whether you are eligible for benefits under the Program, whether you are Disabled, and the amount and duration of your benefits are determined by the plan provisions that were in effect when you became Disabled. For all other purposes (such as the contact information and the claim and appeal process), the provisions of this SPD are applicable to you beginning Jan. 1, 2014.

Section References

Many of the sections of this SPD relate to other sections of the document. You may not obtain all of the information you need by reading only one section. It is important that you review all sections that apply to a specific topic. Also, see the footnotes and notes embedded in the text. They further clarify content, offer additional information or identify exceptions that apply to certain Participants. These notes are important to fully understand Program benefits.

Terms Used in This SPD

Terms that are capitalized are explained in the text of this SPD or defined in the “Definitions” section of the SPD.

CONTENTS

BENEFITS AT A GLANCE

KEY POINTS

- *The Program, which is 100 percent paid by the Company, provides Short-Term Disability Benefits, Long-Term Disability Benefits and Vocational Rehabilitation Benefits to Eligible Employees.*
- *See the "Eligibility and Participation" section for more information on eligibility.*

The AT&T Disability Income Program for Southwest Bargained Employees (Program) provides for ongoing income if you become Partially or Totally Disabled due to an Illness or Injury and are unable to work. The Company pays the full cost of your participation in the Program.

Your Short-Term and Long-Term Disability Benefits work together to provide for your disability coverage. See the *Benefits at a Glance* table.

Short-Term Disability Benefits	
Minimum/Maximum Benefit	50% or 100% of your Pay, based on your Term of Employment and subject to applicable Offsets
Maximum Duration	52 weeks, provided you remain Partially or Totally Disabled
Definition of Disability	You are considered Disabled for purposes of Short-Term Disability Benefits if the Claims Administrator, at its sole discretion, determines that you are Totally Disabled or Partially Disabled. You are considered Totally Disabled when, because of Illness or Injury, you are unable to perform all of the essential functions of your job or another available job assigned by your Participating Company with the same full-time or part-time classification for which you are qualified. You are considered Partially Disabled when, because of Illness or Injury you are unable to perform all of the essential functions of your job or another available job assigned by your Participating Company within the same full-time or part-time classification for which you are qualified, and for the same number of hours that you were regularly scheduled to work before your Partial Disability. See the "When You Are Considered Disabled" section for more information.
Waiting Period	7 (full and/or partial) consecutive calendar days of absence from work for Illness or Injury
When Payments Begin	8th consecutive calendar day of full or partial absence from work as a result of an approved Partial or Total Disability
When Payments End	Generally, the earlier of the date when you return to work, you cease to be Disabled, you have received the maximum 52 weeks of Short-Term Disability Benefits, or your employment is terminated. See the "When Your Short-Term Disability Benefits End" section for more circumstances under which benefits may end.
Benefit Reduction/Offsets	Your benefits will be offset by other applicable sources of income that are available to you. See the "Offsets" section for more information.
Relapse (Successive Periods of Disability)	For benefit information on claims for Participants who have a subsequent Disability after recovering or returning to work from a prior Disability, see the "Relapses" section.

Short-Term Disability Benefits	
Disability Claim Filing	If not filed within 60 days of the first day absent from work, the Claims Administrator will deny any claim and no benefits will be paid unless the Claims Administrator, at its sole discretion, determines that the circumstances warrant an extension of the 60-day period.
Vocational Rehabilitation Benefits	The Program offers Vocational Rehabilitation Benefits which are voluntary if determined to be appropriate by the Claims Administrator to assist certain recipients of Program benefits with training for new employment. Benefits cannot exceed $20,000. See the "Your Vocational Rehabilitation Benefits" section for more information.

Long-Term Disability Benefits	
Coverage Amounts	50% of your Pay when combined with certain other sources of income
Maximum Duration	Age 65 (or beyond if Short-Term Disability Benefits begin at or after age 62) provided you remain Disabled. See the "When Your Long-Term Disability Benefits End" section for more information.
Definition of Disability	You are considered Totally Disabled for purposes of Long-Term Disability Benefits when you have an Illness or Injury that prevents you from engaging in any employment for which you are qualified or may reasonably become qualified based on education, training or experience and you are incapable of performing the requirements of a job other than one for which the rate of pay is less than 50% of your Pay (prior to any Offsets) at the time your long-term disability started. See the "When You Are Considered Totally Disabled" section for more information.
When Payments Begin	On the first day immediately following the end of 52 weeks of Short-Term Disability Benefits, when Long-Term Disability Benefits are approved.
When Payments End	Generally, payments end the earlier of the date you return to work with any of the AT&T Group of Companies, cease to be Disabled, or reach age 65 (unless you are age 62 when your short-term disability begins). See the "When Your Long-Term Disability Benefits End" section for more circumstances under which benefits may end.
Benefit Reduction/Offsets	Your benefits will be offset by other applicable sources of income that are available to you. See the "Offsets" subsection of the "Amount of Long-Term Disability Benefits" section for more information.
Disability Claim Filing	Within 90 days after the end of the period for which Short-Term Disability Benefits are payable.
Vocational Rehabilitation Benefits	The Program offers Vocational Rehabilitation Benefits to assist certain recipients of Program benefits with training for new employment. Benefits cannot exceed $20,000. Vocational Rehabilitation is voluntary if determined to be appropriate by the Claims Administrator. See the "Your Vocational Rehabilitation Benefits" section for more information.

ELIGIBILITY AND PARTICIPATION

KEY POINT

➢ *You must be an Eligible Employee (full-time or part-time) of an Employee Group in a Participating Company listed in Appendix A who is classified as a Regular, Term or Temporary Employee to be eligible for the Program.*

Eligibility at a Glance

This section includes information to help you determine if you are eligible for this Program. Eligible Employees are eligible for the Program on the first day of employment.

Eligible Employee

To be considered an Eligible Employee, you must be on the active payroll of a Participating Company and be included in an Employee Group listed in *Appendix A*. You must also be receiving a regular and stated compensation for your services rendered to a Participating Company as a full-time or part-time Regular, Term, or Temporary Employee.

However, even if you are included in an eligible Employee Group described in the previous paragraph, you are not eligible to participate in the Program if you are classified by the Participating Company as a(n):

- Occasional Employee.
- Leased Employee.
- Independent contractor.
- Nonresident alien employed outside of the United States.
- Bargained Employee who is temporarily promoted to a management position (also known as an acting title).

You are also not eligible to participate in the Program if you are eligible for disability coverage (long-term or short-term) under any other disability benefit program sponsored by AT&T.

- **Special Eligibility Rule for Employees Surplused from AT&T Services, Inc. – National Internet Contract (Tier 2)**

  If you are surplused and move to a job title covered by CWA District 6 Core Contract — Appendix J (Project Lightspeed/U-Verse Job Titles) you will ***not*** *be eligible for the Program.*

Eligibility During a Leave of Absence

You also may be considered eligible if you are granted an approved leave in accordance with the Family and Medical Leave Act (FMLA) or if you are on a Leave of Absence, but only if the terms of your Leave of Absence provide for continued eligibility in this Program.

Eligibility While Suspended From Work

You are not eligible for benefits from the Program while you are absent from work because of a disciplinary suspension.

Participating Companies and Applicable Bargaining Agreements

See *Appendix A* for the list of AT&T companies and bargaining units that participate in the Program.

Term of Employment

Term of Employment (also known as net credited service (NCS)) is determined by the AT&T Pension Benefit Plan.

ENROLLMENT

You are automatically enrolled in the Program if you are an Eligible Employee.

CONTRIBUTIONS

The Company pays the entire cost of the Program; you are not required to contribute.

WHEN COVERAGE BEGINS AND ENDS

Coverage Begins

Your coverage under this Program begins on the date you begin work and fulfill all eligibility requirements. See the "Eligibility and Participation" section for more information.

Coverage under this Program means that you are eligible for Program benefits for an absence from work as a result of a Partial or Total Disability.

Coverage Ends

You are no longer covered under the Program on the date you cease to fulfill any of the eligibility requirements described in this SPD (See the "Eligibility and Participation" section for more information on eligibility). Generally, your coverage under the Program ends on the earliest date when:

- The Program ends.
- You are no longer Disabled under the terms of the Program.
- Your employment is terminated for any reason (including your death or retirement).
- The Program is terminated by the Company for your Employee Group. See *Appendix A* for more information.
- You begin a Leave of Absence unless you continue to be covered as explained in the "Eligibility During a Leave of Absence" section.
- You cease to fulfill any of the eligibility requirements described in this SPD. (See the "Eligibility and Participation" section for more information.)
- The Company may, from time to time, move job positions that are covered by the Program out of the Program (for example, a group of jobs may be transferred to coverage under another disability program). If that happens while you are Disabled and receiving Short-Term Disability Benefits or Long-Term Disability Benefits from the Program (or would be receiving benefits in the absence of Offsets), you will continue to be covered by this Program until you are no longer considered Disabled. Once you are no longer considered Disabled, your eligibility for coverage under the Program will cease.

But, you will continue to be covered by the Program after employment ends if:

- You terminate employment from an Employee Group in a Participating Company and are immediately employed or reemployed by another Employee Group in a Participating Company listed in *Appendix A*. See *Appendix A* for more information.
- You are receiving Long-Term Disability Benefits from this Program.

DISCONTINUANCE OF BENEFITS UNDER THE PROGRAM

Your benefits under the Program will end on the earliest day any of the following events occur:

- You return to work anywhere else or if you are working as part of an approved vocational rehabilitation plan under the Program, and the job pays more than 50 percent of your Pay before your long-term disability started. The sum of the Long-Term Disability Benefits payable and the pay you receive from working cannot exceed 75 percent of your Pay at the time your long-term disability started.
- You no longer meet the requirements for Partial Disability or Total Disability as determined at the sole discretion of the Claims Administrator.
- You receive the maximum 52 weeks of Short-Term Disability Benefits payable unless you are approved for Long-Term Disability Benefits by the Claims Administrator.
- You receive the maximum duration of Long-Term Disability Benefits.
    - See "When Your Long-Term Disability Benefits End" in the "Your Company-Provided Long-Term Disability Benefits" section.
- You do not comply with one or more terms of the Program.
- The Program ends.
- You die.

Although you are otherwise eligible and may have been approved for benefits under the Program, all benefits under the Program will be denied or discontinued on the earliest day that any of the following events occur:

- You are not under the appropriate care and treatment of a Physician during your Partial Disability or Total Disability.
- You do not take proper care of yourself, follow the recommended treatment plan and/or receive proper treatment for your condition.
- You fail to provide Medical Evidence or other information reasonably required by the Claims Administrator for purposes of administering your claim.
- You do not cooperate in a medical examination or interview or fail to make yourself available for an examination as directed by the Claims Administrator.
- During a Short-Term Disability Benefits absence, you travel away from home (outside a 60-mile radius or overnight) without obtaining prior permission from both the Claims Administrator and your Physician. Each request for travel is determined on an individual basis.

IMPORTANT: Travel away from home (outside a 60-mile radius or overnight) during a Short-Term Disability Benefits absence is not permitted without prior permission of the Claims Administrator. Contact the Claims Administrator if you need to recuperate away from home during a Short-Term Disability Benefits absence. No benefits are payable unless the Claims Administrator has approved this request based on medical necessity.

- You decline to return to your own job, or another available job assigned by your Participating Company while receiving Short-Term Disability Benefits when you are medically able to do so as determined at the discretion of the Claims Administrator.
- You are receiving wages from a Participating Company (unless you are receiving Short-Term Disability Benefits for a Partial Disability).
- You fail to file a claim for Short-Term Disability Benefits within 60 days from your first day of absence unless the Claims Administrator, at its sole discretion, determines that the circumstances warrant an extension.
- You fail to file a claim for Long-Term Disability Benefits within 90 days of receiving 52 weeks of Short-Term Disability Benefits unless the Claims Administrator, at its sole discretion, determines that the circumstances warrant an extension.
- A suit for damages or other legal action is brought by you against any member of the AT&T Group of Companies or an employee of AT&T because of your Injury or Illness (except for an action to enforce your ERISA rights).
- You have full-time or part-time employment with another non-AT&T employer (including a self-owned or family-owned business).
- You do not follow your vocational rehabilitation plan, if applicable.

YOUR SHORT-TERM DISABILITY BENEFITS

KEY POINTS

- *Short-Term Disability Benefits under the Program may be available if you are determined by the Claims Administrator to have a Total Disability or Partial Disability. Short-Term Disability Benefits under the Program are payable beginning on the eighth full and/or partial calendar day of continuous absence as a result of an approved Total or Partial Disability.*
- *The amount of Short-Term Disability Benefits depends on your Pay and your Term of Employment.*
- *Short-Term Disability Benefits are payable for a maximum of 52 weeks while you are Partially or Totally Disabled.*
- *Your Short-Term Disability Benefits will be reduced by certain other income sources known as Offsets.*

When You Are Considered Disabled

You are considered Disabled for purposes of Short-Term Disability Benefits if the Claims Administrator determines that you are Totally Disabled or Partially Disabled.

You are not eligible to receive Short-Term Disability Benefits if your Partial or Total Disability is caused by or contributed to by any Injury or Illness sustained as a result of any of the following:

- Your committing or attempting to commit, a felony or any other crime.
- Your service in the military.
- War, or any act of war, declared or undeclared, or any hazard of war (unless on Company business, including travel, assignment and relocation outside the United States).
- Your active participation in a riot, insurrection, rebellion or civil commotion.
- Your intentionally self-inflicted Injury while sane or insane.

When You Are Considered Totally Disabled

You are considered Totally Disabled when, because of Illness or Injury, you are unable to perform all of the essential functions of your job or another available job assigned by your Participating Company with the same full-time or part-time classification for which you are qualified.

When You Are Considered Partially Disabled

You are considered Partially Disabled when, because of Illness or Injury, you are unable to perform all of the essential functions of your job or another available job assigned by your Participating Company within the same full-time or part-time classification for which you are qualified, for the same number of hours that you were regularly scheduled to work before your Partial Disability. No Short-Term Disability Benefits will be paid if you do not return to work when you are approved as Partially Disabled.

Filing for Short-Term Disability Benefits

In order to be considered for Short-Term Disability Benefits under the Program, you must:

- Be an Eligible Employee. You must meet the eligibility requirements before the eighth full or partial consecutive calendar day of absence from work as a result of a Total or Partial Disability. See the "Eligibility and Participation" section for more information on eligibility.
- Contact your supervisor, or appropriate designated representative, as soon as reasonably practicable to report your absence.
- Contact the Claims Administrator as soon as you know your absence will be greater than seven full or partial consecutive calendar days (but no later than 60 days after your first day absent from work). See the "Contact Information" section for information on how to contact the Claims Administrator. If you are unable to call the Claims Administrator or provide the necessary information to the Claims Administrator, your Physician, supervisor, or any member of your family may make these calls on your behalf.
- Be under the care of a Physician and follow a treatment plan that is reasonably designed (where practicable) to result in your recovery and return to work. The Claims Administrator will require that you periodically furnish satisfactory Medical Evidence of your Partial or Total Disability from your Physician.
- Ensure that your medical providers cooperate with the Claims Administrator to provide all necessary information to the Claims Administrator in a timely manner.

- Provide your Physician or other medical provider with a signed copy of the medical release form provided by the Claims Administrator.
- Report for a medical examination by a Physician designated by the Claims Administrator if the Claims Administrator requires this examination to initially qualify for or continue your Short-Term Disability Benefits. If the Claims Administrator requires this examination, you will not be required to pay for the medical examination.
- Contact the Claims Administrator in advance to obtain permission if you plan to travel away from home (outside a 60-mile radius or overnight) while you are receiving Short-Term Disability Benefits. See the "Discontinuance of Benefits Under the Program" section for more information about traveling while receiving Short-Term Disability Benefits.

> **IMPORTANT:** Travel away from home (outside a 60-mile radius or overnight) while receiving Short-Term Disability Benefits is not permitted without prior permission from the Claims Administrator.
>
> If you have any questions about these policies, or if you are unsure if an activity is appropriate, contact the Claims Administrator.

Only the Claims Administrator (or its delegates) has the discretion to determine whether you have a disability that qualifies you for Short-Term Disability Benefits under the Program.

If you do not file your claim for Short-Term Disability Benefits within 60 days of your first day absent from work, the Claims Administrator will deny your claim and no Short-Term Disability Benefits will be payable unless the Claims Administrator, at its sole discretion, determines that the circumstances warrant an extension of the 60-day period.

See the "Additional Information About Filing a Claim for Benefits Under the Program" section for information about filing a claim.

When Short-Term Disability Benefits Begin

Your Short-Term Disability Benefits begin on the eighth full and/or partial consecutive calendar day that you are away from work as a result of an approved Total Disability and/or Partial Disability (unless your absence begins within two weeks of a previous short-term disability absence -- see the "Relapses" section). A partial absence occurs when you are absent for at least one-half of the scheduled workday.

> **EXAMPLE:** Mary is an Eligible Employee who is first absent from work as a result of an Illness or Injury beginning on Dec. 16. If her absence continues until Dec. 23, her Short-Term Disability Benefits would begin on Dec. 23 (eighth calendar day of absence) if approved. If Mary's first day of absence is Dec. 18, her eighth consecutive calendar day of absence is Dec. 25 — a holiday that Mary is not scheduled to work. If Mary returns to work on Dec. 26, she will not have had a short-term disability under the Program. If she is still absent on Dec. 26 as a result of her approved Disability, she will begin receiving Short-Term Disability Benefits as of Dec. 25.

If the seven-day waiting period is interrupted by a return to work of more than one-half of your scheduled workday, you must complete a new seven-day waiting period before Short-Term Disability Benefits begin.

Amount and Duration of Short-Term Disability Benefits

Your Short-Term Disability Benefits can last up to 52 weeks if you remain Disabled. The amount of your Short-Term Disability Benefits depends upon your Term of Employment and

your Pay, both as of the first calendar day your Short-Term Disability Benefits begin, as the chart below shows.

Term of Employment as of the 8th day of absence	Weeks at full Pay (100 Percent of Pay)	Weeks at half Pay (50 Percent of Pay)
0 but less than 2 years	4	48
2 but less than 5 years	8	44
5 but less than 15 years	13	39
15 but less than 20 years	26	26
20 but less than 25 years	39	13
25 or more years	52	0

If you are Partially Disabled, you will be paid regular compensation for the partial days you work and you will receive Short-Term Disability Benefits for the partial days you do not work, as fully scheduled before your Partial Disability. The time you are Partially Disabled and work a partial schedule will count as full days against your maximum 52 weeks of Short-Term Disability Benefits. No Short-Term Disability Benefits will be paid if you do not return to work when you are approved for Partial Disability. The time you are approved for Partial Disability and work a partial schedule will count as full days against your 52-week of Short-Term Disability Benefits. Under no circumstances will you receive Short-Term Disability Benefits beyond the 52-week maximum of Short-Term Disability Benefits when periods of Total Disability and Partial Disability are combined.

> **EXAMPLE:** If you are approved for Total Disability for six weeks and then you are approved for Partial Disability of four hours a day for two weeks, the six weeks of Total Disability and the two weeks of Partial Disability will be added together to reduce the 52-week maximum of Short-Term Disability Benefits you can receive under the Program.

No Short-Term Disability Benefits are payable when wages (including vacation pay or other payments during temporary absence) is payable by a Participating Company.

Pay

"Pay" means the amount identified to be used for computing disability benefits in your Participating Company's compensation plan or the collective bargaining agreement applicable to you and in effect as of your first day of short-term disability absence. For employees paid pursuant to a leveraged compensation plan, Pay will be based on base wages plus 100 percent of the target incentive amount, as defined under the collective bargaining agreement. In the absence of a compensation plan or a collective bargaining agreement applicable to you, Pay means your rate of earnings as of your first day of short-term disability absence (not including any payments for overtime). No increases or other changes in your Pay will be effective until you return to work on a part-time or full-time basis.

- **Special Rule for Part-Time Employees**

  The amount of your Short-Term Disability Benefits will be calculated based upon your part-time Pay based on the number of hours you are scheduled to work per week.

Offsets

Your Short-Term Disability Benefits will be offset (reduced) by any of the following sources of income available to you, including but not limited to:

- Workers' Compensation Benefits. If you are unable to work as a result of a work-related disability, you may be eligible to receive Workers' Compensation Benefits. Workers' Compensation Benefits, including permanent disability, will reduce your Short-Term Disability Benefits. The Program will offset your benefit by Workers' Compensation Benefits only if they are payable for the same Injury, Illness, condition or Partial or Total Disability for which you are receiving Short-Term Disability Benefits from this Program. Your benefits will not be offset by attorney fees or court costs you receive in connection with your Workers' Compensation claim.

- Social Security Disability Insurance (SSDI) and/or Social Security Retirement Benefits under the Social Security Act. Only the Primary Social Security Benefit amount will be taken into account; the Offset will not be recalculated if you later receive an increase, such as cost of living, in your Social Security award amount. If you receive a retroactive lump sum of your Social Security award that covers any time period in which you received Short-Term Disability Benefits, it will result in an overpayment for which repayment to the Program will be necessary. You must apply for Social Security benefits, and you must exhaust all administrative remedies if you are initially denied. If you do not apply for Social Security benefits, the Claims Administrator will use an estimate of your monthly Social Security benefits for offset purposes. If an estimate is used and your Social Security benefits are denied on final appeal, you will be refunded the amount that was withheld from your monthly Short-Term Disability Benefits. You will be directed by the Claims Administrator to a representative who will assist you in filing for Social Security benefits.

- State Disability Insurance (SDI) and other benefits of the same general character under any state or federal disability law now in force or under any future law, such as benefits under disability insurance laws of any other state, or the functional equivalent of Workers' Compensation Benefits but excluding benefits for military service or under the Social Security Act. You must pursue any applicable appeals if your claim is denied. The Plan Administrator has the sole discretion to determine what payments under current or future laws are of the same general character as benefits under the Program.

- Veterans' benefits.

This means that if the amount you receive from Offsets is less than the applicable percentage of your Pay, Short-Term Disability Benefits provide additional payments to bring your total disability income up to that level. If your combined income from the Offsets is equal to or greater than the applicable percentage of your Pay, you will not receive payments from the Program. The Program may seek to recover any overpayments that you receive.

EXAMPLE: Suppose you have five years of Term of Employment, and your weekly Pay is $700. Suppose further that your Total Disability was as a result of an on-the-job injury, and you are receiving Workers' Compensation Benefits of $490 per week. The Claims Administrator approves you for Short-Term Disability Benefits at 100 percent of $700 per week. Since you are receiving Workers' Compensation Benefits of $490 per week, you will receive Short-Term Disability Benefits of $210 per week to bring your total weekly benefit up to $700 (equal to 100 percent of Pay).

If your short-term disability is still approved by the Claims Administrator after 13 weeks, you will be eligible to receive Short-Term Disability Benefits at half Pay. However, if Workers' Compensation Benefits of $490 per week continue, you will not receive any payments from the Program because the $490 per week of Workers' Compensation Benefits is more than Short-Term Disability Benefits at half Pay.

Furthermore, if Short-Term Disability Benefits and Offsets are payable or awarded at different times for the same periods of Partial or Total Disability, Short-Term Disability Benefits will be adjusted to take the Offsets into account.

EXAMPLE: If you receive retroactive Workers' Compensation Benefits four months after you have begun receiving Short-Term Disability Benefits, you will be considered to have been overpaid by the Program for those first four months, and future Short-Term Disability Benefits will be reduced to reflect the future Workers' Compensation Benefits and to recapture the past overpayments. In some cases, the Program may determine that you have received an overpayment for which repayment to the Program will be necessary.

There is no time limit on when Offsets can be applied. The Plan Administrator and Claims Administrator may choose, for administrative reasons, to establish rules that result in deferring application of certain offsets. Failure to apply an Offset as soon as it is available will not constitute a waiver by the Program of offset rights or otherwise prevent their later exercise.

IMPORTANT: No Short-Term Disability Benefit payable under the Program will be reduced by reason of any governmental benefit payable for military service.

Relapses

If you return to work full-time on your regular schedule following a short-term disability and experience a relapse, you may be eligible for Short-Term Disability Benefits for your relapse depending upon the length of your original short-term disability and the length of time you returned to active work not including time while on a Leave of Absence. Note that this section applies whether your relapse is for the same Partial or Total Disability or a different one.

If you return to work after receiving less than the maximum 52 weeks of Short-Term Disability Benefits

If you return to work for 13 weeks or more of continuous active employment following your original short-term disability of less than 52 weeks and are again Partially or Totally Disabled, you are eligible for a new 52 weeks of Short-Term Disability Benefits on the eighth full and/or partial calendar day of a continuous period of absence.

If you return to work for more than two weeks (14 calendar days) but less than 13 weeks of continuous active employment and are again Partially or Totally Disabled, you are not eligible for a new 52-week maximum benefit. Your Short-Term Disability Benefits will begin again on

the eighth consecutive full and/or partial calendar day of absence. Your earlier period of disability absence will be counted with your later period of disability absence, and your maximum benefit will be a total of 52 weeks. Your previous disability absence will be counted in determining whether you are eligible for full Pay, half Pay or both.

If you return to work for two weeks or less and are again Partially or Totally Disabled, you are not eligible for a new 52-week maximum benefit. Your Short-Term Disability Benefits will begin on the first day of the disability absence period. Your prior period of disability absence will be counted with your later period of disability absence, and your maximum benefit will be a total of 52 weeks. Your previous disability absence will be counted in determining whether you are eligible for 100 percent of Pay, 50 percent of Pay or both.

> **EXAMPLE:** Suppose Don became Totally Disabled and was unable to work for six weeks. He has 4 years of service. He returned to work and within two weeks was again Totally Disabled.
>
> Since Don had 4 years of service, he is eligible for eight weeks of full Pay and 44 weeks of 50 percent of Pay. After the seven-day waiting period, Don received six weeks of full Pay. After his relapse, Don can receive Short-Term Disability Benefits on the first day of this absence. If he remains Totally Disabled, he will be eligible to receive two weeks of 100 percent of Pay and the remaining 44 weeks of 50 percent of Pay.

If you were considered disabled under the terms of another Company disability plan or program, then returned to work and transferred into coverage under this Program, and then become Disabled under the terms of this Program, the determination of whether you have had a relapse will be made under the terms of this Program. The time period for which you received disability benefits under the previous program will be counted in determining how much time you may receive Short-Term Disability Benefits under this Program. For example, if you had received eight weeks of short-term disability benefits under the previous program, transferred into this Program, and then relapsed, you will be treated during the relapse period as if you had already received eight weeks of Short-Term Disability Benefits from this Program.

If you return to work after receiving the maximum 52 weeks of Short-Term Disability Benefits

If you received the maximum of 52 weeks of Short-Term Disability Benefits during your previous disability absence, you must return to work for 26 continuous weeks or more before you can again be eligible for Short-Term Disability Benefits.

If you return to work for more than two weeks (14 calendar days) but less than 26 continuous weeks following receipt of 52 weeks of Short-Term Disability Benefits, you will not be eligible for any additional Short-Term Disability Benefits.

However, you may be eligible for Long-Term Disability Benefits. If approved by the Claims Administrator, your Long-Term Disability Benefits begin on the eighth consecutive calendar day of full or partial absence.

If you return to work at least one day, but no more than two weeks (14 calendar days) following receipt of 52 weeks of Short-Term Disability Benefits, you will not be eligible for any additional Short-Term Disability Benefits. However, you may be eligible for Long-Term Disability Benefits. If approved by the Claims Administrator, your Long-Term Disability Benefits begin on the first calendar day of full absence.

How Your Short-Term Disability Benefits Are Paid

Your Short-Term Disability Benefits will be paid as soon as practicable following a determination that you have a Disability and at the same time as wages or salary are paid by

the Participating Company, except that arrears may be paid in a single sum (calculated using the factors described in the "Pay" section). The Plan Administrator may, at its discretion, direct that Short-Term Disability Benefits be paid monthly. Additionally, under current law, Short-Term Disability Benefits are considered federal taxable income.

When Your Short-Term Disability Benefits End

Your Short-Term Disability Benefits end on the earliest day any of the following events occur:

- You are no longer Disabled under the terms of the Program.
- You return to work with the AT&T Group of Companies. (Exception: If your return to work is as a result of the Claims Administrator determining, at its sole discretion, that you are eligible for Partial Disability benefits.)
- Your employment with the AT&T Group of Companies ends for any reason.
- You take a Leave of Absence, unless otherwise indicated by the applicable Leave of Absence.

Your Short-Term Disability Benefits may also be discontinued for the reasons listed in the "Discontinuance of Benefits Under the Program" section.

Impact on Your Employment Status

If you reach the end of your 52 weeks of Short-Term Disability Benefits and do not return to work, your employment status will be determined under your Participating Company's policies which, at this time, generally provide that your employment will be terminated unless you are approved for a Leave of Absence. The termination, as administered under your Participating Company's policies, will generally occur even if you are approved for Long-Term Disability Benefits. Contact your supervisor if you have any questions about your employment status. Refer to the Leave of Absence policy that applies to your Employee Group for more information on any Leave of Absence you may be eligible to receive.

Following 52 weeks of Short-Term Disability Benefits, reinstatement within one year to an available Company job that you are qualified to perform will be provided if Medical Evidence is submitted to the Claims Administrator to substantiate that you are able to return to work. See the "Contact Information" section for information on how to contact the Claims Administrator. This one-year period during which you may be reinstated includes any period of Leave of Absence.

YOUR LONG-TERM DISABILITY BENEFITS

KEY POINTS

- *If you are approved to receive Long-Term Disability Benefits, your benefits will begin on the first day immediately following your 52 weeks of Short-Term Disability Benefits.*
- *The Program pays Long-Term Disability Benefits that equal 50 percent of your Pay, reduced by the listed Offsets.*
- *Long-Term Disability Benefits will continue for most Eligible Employees until age 65 if you remain Totally Disabled for purposes of Long-Term Disability Benefits.*
- *If you are receiving Long-Term Disability Benefits, your employment with the AT&T Group of Companies will be considered terminated unless you are approved for a Leave of Absence.*

This Program provides Long-Term Disability Benefits to Eligible Employees who are Totally Disabled on the first day immediately following 52 weeks of Short-Term Disability Benefits.

When You Are Considered Totally Disabled

You are considered Totally Disabled for purposes of Long-Term Disability Benefits under this Program when you have an Illness or Injury that prevents you from engaging in any employment for which you are qualified or may reasonably become qualified based on education, training or experience. You will be considered Totally Disabled for a long-term disability if you are incapable of performing the requirements of a job other than one for which the rate of pay is less than 50 percent of your Pay (prior to any Offsets) at the time your long-term disability started.

However, you are allowed to work and still receive Long-Term Disability Benefits if the job pays less than 50 percent of your Pay before your Total Disability started. The Long-Term Disability Benefits payable when added to the pay you receive from working cannot exceed 75 percent of your Pay at the time your long-term disability started.

You will be considered Totally Disabled during the period in which you are attempting to qualify for an occupation or employment by actively pursuing a vocational rehabilitation plan. See the "Your Vocational Rehabilitation Benefits" section for a description of Vocational Rehabilitation Benefits.

You are **not** eligible to receive Long-Term Disability Benefits if your Total Disability is caused by or contributed to by any Injury or Illness sustained as a result of any of the following:

- Your committing or attempting to commit a felony or any other crime.
- Your intentionally self-inflicting an Injury (whether or not you are sane or insane when inflicted).
- Military service or war, declared or undeclared, or any act or hazard of war (unless on Company business, including travel, assignment and relocation outside of the United States).
- Your active participation in a riot, insurrection, rebellion or civil commotion.

Filing for Long-Term Disability Benefits

As a general rule, shortly before you reach the end of the 52-week period during which you received Short-Term Disability Benefits under the Program, the Claims Administrator will send you the appropriate forms to apply for Long-Term Disability Benefits, as well as information on filing for Social Security Disability Insurance benefits. If you are within a few days of the end of the 52-week Short-Term Disability Benefits period and you have not received the forms to apply for Long-Term Disability Benefits, contact the Claims Administrator. See the "Contact Information" section for information on how to contact the Claims Administrator.

In order to be considered for Long-Term Disability Benefits, you must:

- Be an Eligible Employee. See the "Eligibility and Participation" section for more information on eligibility.
- Have received the maximum amount (52 weeks) of Short-Term Disability Benefits under the Program.
- Ensure that your medical providers cooperate with the Claims Administrator to provide all necessary information described in this section.
- Provide your Physician or other medical provider a signed copy of the medical release form provided by the Claims Administrator.

- File an application for Long-Term Disability Benefits with the Claims Administrator no later than 90 days after the end of the period for which Short-Term Disability Benefits are payable (not 90 days from the date you receive your last short-term disability payment). See the "Contact Information" section for the mailing address of the Claims Administrator.
- Be under the care of a Physician and follow his or her recommended treatment. The Claims Administrator will require that you periodically furnish satisfactory Medical Evidence of your Total Disability.
- Report for a medical examination by a Physician designated by the Claims Administrator if the Claims Administrator requires this examination to initially qualify for or continue your Long-Term Disability Benefits. In this event, you will not be required to pay for the medical examination.

Only the Claims Administrator has the discretion to determine whether you have a disability that qualifies you for Long-Term Disability Benefits under the Program. If you do not file your claim for Long-Term Disability Benefits within 90 days after the end of the period for which Short-Term Disability Benefits are payable, the Claims Administrator will deny your claim and no Long-Term Disability Benefits will be payable unless the Claims Administrator, at its sole discretion, determines that the circumstances warrant an extension of the 90-day period. See the "Additional Information About Filing a Claim for Benefits Under the Program" section for information about filing a claim.

When Long-Term Disability Benefits Begin

Your Long-Term Disability Benefits begin on the first day immediately following the end of the 52-week period during which you received Short-Term Disability Benefits from this Program, provided that at the end of the 52-week period you are considered Totally Disabled.

Impact on Your Employment Status

Even if you are approved for Long-Term Disability Benefits, your employment ends when you have reached your maximum Short-Term Disability Benefits unless you are approved for a Leave of Absence. Refer to the Leave of Absence policy that applies to you for more information on any Leave of Absence you may be eligible to receive.

Amount of Long-Term Disability Benefits

The Program pays Long-Term Disability Benefits that equal 50 percent of your Pay, offset (reduced) by other sources of income listed in the "Offsets" section below.

Pay

Pay is the amount identified for computing disability benefits in your Participating Company's compensation plan or the collective bargaining agreement applicable to you and in effect, as of the day immediately before the start of your Long-Term Disability Benefits. For employees paid pursuant to a leveraged compensation plan, Pay will be based on base wages plus 100 percent of the target incentive amount, as define under the collective bargaining agreement. In the absence of a compensation plan or collective bargaining agreement applicable to you, Pay is your rate of earnings that you are entitled to receive as payment from your employing Participating Company for your services determined as if you were actively at work on the day immediately before the start of Long-Term Disability Benefits (not including any payments for overtime). However, if your compensation is ordinarily computed by including sales commissions, in addition to your rate of earnings, your Pay includes your average monthly sales commission (not including compensation for overtime) for the lesser of the following periods:

- The preceding twelve (12) months in the service of the Participating Company that employs you.
- The total preceding continuous period of service with your employing Participating Company.

- **Special Rule for Part-Time Employees**

  The amount of your Long-Term Disability Benefits is calculated based upon your part-time Pay based on the number of hours you are scheduled to work per week.

Offsets

Your Long-Term Disability Benefits will be offset (reduced) by any of the following sources of income available to you, including but not limited to:

- Workers' Compensation Benefits. If you are unable to work as a result of a work-related disability, you may be eligible to receive Workers' Compensation Benefits. Workers' Compensation Benefits, including permanent disability, will reduce your Long-Term Disability Benefits. The Program will offset your benefit by Workers' Compensation Benefits only if they are payable for the same Injury, Illness, condition or Total Disability for which you are receiving Long-Term Disability Benefits from this Program. Your benefits from the Program will not be offset by attorney fees or court costs you receive in connection with your Workers' Compensation claim.
- Social Security Disability Insurance (SSDI) and/or Social Security Retirement Benefits under the Social Security Act. Only the Primary Social Security Benefit will be taken into account. The Offset will not be recalculated if you later receive an increase, such as cost of living, in your Social Security award amount. If you receive a retroactive lump sum of your Social Security award that covers any time period in which you received Short-Term or Long-Term Disability Benefits, it will result in an overpayment for which repayment to the Program will be necessary. You must apply for Social Security benefits, and you must exhaust all administrative remedies if you are initially denied. If you do not apply for Social Security benefits, the Claims Administrator will use an estimate of your monthly Social Security benefits for offset purposes. If an estimate is used and your Social Security benefits are denied on final appeal, you will be refunded the amount that was withheld from your monthly Long-Term Disability Benefits. You will be directed by the Claims Administrator to a representative who will assist you in filing for Social Security benefits.

  IMPORTANT: You and your Participating Company both pay Social Security taxes to provide benefits at retirement or if you become Disabled. If you qualify, you may receive Social Security Disability Insurance benefits. Social Security Disability Insurance benefits are not paid automatically, so you must apply for them in all cases. Social Security uses a different definition of "disability" than the Program. There may be circumstances where you may be considered "disabled" by Social Security but not by the Program.

- Pension in pay status from any pension plan sponsored by the AT&T Group of Companies (including both qualified and non-qualified payments for disability, service, or vested pension). Your Program benefits will be reduced in the amount equal to the amount payable to you as a monthly single life annuity, whether or not you actually elect this form of payment. For example, if you elect a lump sum cash-out to be paid to you in cash or roll it over into a traditional individual retirement account (IRA) or an Eligible Retirement Plan (as defined by the Internal Revenue Code), the equivalent monthly single life annuity amount will be calculated and your Long-Term Disability Benefits will be reduced by that amount each month. Once the amount of your pension

benefit is determined and paid, any increase in your pension benefit due to a pension plan amendment will not decrease the amount of your Long-Term Disability Benefits.

- State Disability Insurance (SDI) and other benefits of the same general character under any state or federal disability law, such as benefits under disability insurance laws of any other state, or the functional equivalent of Workers' Compensation Benefits. You must pursue any applicable appeals if your claim is denied. The Plan Administrator has the sole discretion to determine what payments under current or future laws are of the same general character as benefits under the Program.

This means that if the amount you receive from Offsets is less than 50 percent of your Pay, Long-Term Disability Benefits provide additional payments to bring your total disability income up to that level. If your combined income from Offsets is equal to or greater than 50 percent of your Pay, you will not receive payments from the Program. The Program may seek to recover any overpayments that you receive.

If Long-Term Disability Benefits and Offsets are payable or awarded at different times or for different periods of Total Disability, the Long-Term Disability Benefits will be adjusted to take the Offsets into account.

> **EXAMPLE:** If you receive Workers' Compensation Benefits or a settlement of those benefits while, or after, you have been receiving Long-Term Disability Benefits from this Program, your future Long-Term Disability Benefits will be reduced to reflect the amount of the payment. In some cases, the Claims Administrator may determine that you have received an overpayment for which repayment to the Program will be necessary.

There is no time limit on when Offsets can be applied. The Plan Administrator and Claims Administrator may choose, for administrative reasons, to establish rules that result in deferring application of certain Offsets. Failure to apply an Offset as soon as it is available will not constitute a waiver by the Program of offset rights or otherwise prevent their later exercise.

> **IMPORTANT:** No Long-Term Disability Benefits payable under the Program will be reduced by reason of any governmental benefit payable for military service.

How Long-Term Disability Benefits Are Paid

Any Long-Term Disability Benefits you receive are payable monthly. If payment has not been approved by the Claims Administrator in time to do so or if payment is approved following a review of a denied claim for Long-Term Disability Benefits, Long-Term Disability Benefits will be paid to you as soon as practicable on a monthly basis following approval of the Long-Term Disability Benefits, and any amounts in arrears may be paid in a single sum. Additionally, under current law, the Long-Term Disability Benefits are considered federal taxable income.

When Your Long-Term Disability Benefits End

Your Long-Term Disability Benefits end when the first of the following events occur:

- You return to work with any of the AT&T Group of Companies.
- You are no longer Disabled or Totally Disabled under the terms of the Program.

- If you have not reached age 62 on the date your Short-Term Disability Benefits under this Program begin, your Long-Term Disability Benefits end on the date you reach age 65 assuming you continue to be Totally Disabled. If you have reached age 62 on the date your Short-Term Disability Benefits under this Program begin, your Long-Term Disability Benefits end, assuming you remain Disabled or Totally Disabled, as follows:

Your Age on the Date Your Short-Term Disability Benefits Began:	Maximum Period of Benefits Under the Program:*
Age 61 or younger	To age 65
Age 62	3½ years
Age 63	3 years
Age 64	2½ years
Age 65	2 years
Age 66	1¾ years
Age 67	1½ years
Age 68	1¼ years
Age 69 or older	1 year
Including any period of Short-Term Disability Benefits	

- Your Long-Term Disability Benefits may also be discontinued for the reasons listed in "Discontinuance of Benefits Under the Program" section.

YOUR VOCATIONAL REHABILITATION BENEFITS

KEY POINTS

- *Vocational Rehabilitation Benefits train you for new employment if you become Partially or Totally Disabled.*
- *The total Vocational Rehabilitation Benefits cannot exceed $20,000.*

The Program offers Vocational Rehabilitation Benefits to assist certain recipients of Program benefits with training for new employment.

IMPORTANT: Vocational rehabilitation is voluntary. If you do not follow your vocational rehabilitation plan, all of your Program benefits may be discontinued (see "Discontinuance of Benefits Under the Program" section).

Who Qualifies for Vocational Rehabilitation Benefits

To receive Vocational Rehabilitation Benefits from this Program, you must both:

- Be currently receiving Short-Term or Long-Term Disability Benefits from this Program.
- Have a vocational rehabilitation plan that is approved by the Claims Administrator.

There are two ways that you can obtain a vocational rehabilitation plan. The Claims Administrator might select you for Vocational Rehabilitation Benefits. If this occurs, you will be notified in writing of your selection. If you are not selected, you may apply to the Claims Administrator for Vocational Rehabilitation Benefits using the appeal procedures of this

Program. See the "How to Appeal a Denied Claim" section for more information. The Claims Administrator, at its sole discretion, will determine whether Vocational Rehabilitation Benefits are appropriate.

The Claims Administrator or a vocational rehabilitation agency or counselor will develop a vocational rehabilitation plan for you. This training is tailored to your abilities, skills and interests.

The Claims Administrator will approve a vocational rehabilitation plan only if, at its discretion, it determines that it would be cost effective for the Program to extend such benefits to you, or if the Claims Administrator requires you to submit to a vocational evaluation.

You will be required to comply with the vocational rehabilitation plan that is prepared for you as a condition of receiving your Short-Term or Long-Term Disability Benefits from this Program.

You will not be eligible for more than one vocational rehabilitation plan.

Amount of Vocational Rehabilitation Benefits

This Program reimburses you for Covered Expenses incurred pursuant to a vocational rehabilitation plan in an amount up to $20,000, during the timeframe specified in the "When Your Expenses Must Be Incurred" section.

What Expenses Are Covered

Covered Expenses in general are those expenses required for completion of a vocational rehabilitation plan. The following expenses are covered:

- Vocational rehabilitation evaluation, counseling and job placement services.
- On-the-job training expenses.
- Licenses or certificates for the vocational goal.
- Training facility tuition.
- Books and educational supplies.
- Tools and equipment customarily required as a condition of employment or necessary to complete training.
- Certain transportation and relocation expenses.
- Reasonable child care costs when required for participation in a vocational rehabilitation plan.
- Clothing required by the vocational rehabilitation plan or by type of work activities.

What Expenses Are Not Covered

The following expenses are **not** covered:

- Capital investment for a rehabilitation plan involving self-employment.
- Capital tool and equipment expenses.
- Normal commuting expenses to an employment location.
- Expenses not required for completion of a vocational rehabilitation plan.

When Your Expenses Must Be Incurred

Your expenses must be incurred on or after the date that you first become entitled to Vocational Rehabilitation Benefits and within 24 months following the date on which your vocational rehabilitation plan is approved and accepted. An expense is considered incurred on the date that you receive the vocational rehabilitation service, not on the date you are billed or the date on which you pay your bill.

When Vocational Rehabilitation Benefits Begin

You will be notified if you have been selected for Vocational Rehabilitation Benefits.

How Your Benefits Are Paid

The notification will describe the procedure under which you may submit claims for reimbursement for expenses incurred during a vocational rehabilitation plan.

Duplicate Payments

You may not receive duplicate payments from this Program and any vocational rehabilitation obligation under applicable workers' compensation laws.

If you become eligible for vocational rehabilitation benefits pursuant to applicable workers' compensation laws, you will receive those benefits but no Vocational Rehabilitation Benefits will be payable to you from this Program.

If you begin receiving Vocational Rehabilitation Benefits from this Program and later claim a vocational rehabilitation benefit under applicable workers' compensation laws, your Vocational Rehabilitation Benefits from this Program will be considered an advance of your statutory benefit and shall be offset against any payment or award made to you under applicable workers' compensation laws.

FINAL UNPAID BENEFITS UNDER THE PROGRAM

If you die, benefits under the Program will be paid through the date of your death to your designated beneficiary. If you have not designated a beneficiary, benefits under the Program will be paid in accordance with the AT&T Beneficiary Designation Rules. For a copy of this Beneficiary Designation Form, call the Fidelity Service Center, or access the form at **www.netbenefits.fidelity.com.**

BENEFITS PROVIDED UNDER OTHER PLANS OR PROGRAMS

For eligibility regarding other health and life insurance benefits that you may be eligible for while receiving benefits under the Program, refer to the SPD that governs eligibility for the applicable benefit plan.

ADDITIONAL INFORMATION ABOUT FILING A CLAIM FOR BENEFITS UNDER THE PROGRAM

KEY POINT

- *Generally, you will receive a written notice within 45 days from the Claims Administrator whether your claim for benefits is approved or denied.*

When you make a claim for benefits under the Program, the Program's Claims Administrator will notify you of the decision regarding your claim within 45 days of the date your claim is received by the Claims Administrator. The Claims Administrator may extend this 45-day period

for up to 30 days (plus an additional 30 days if needed) if it determines that special circumstances outside of the Program's control require more time to determine your claim.

You will be notified within the initial 45-day period (and within the first 30-day extension period if an additional 30 days are needed) whether additional time is needed and what special circumstances require the extra time. If extensions are required because the Claims Administrator needs additional information from you, you will have 45 days from the Claims Administrator's notification to provide that information. Once you have provided the information, the Claims Administrator will decide your claim within the time remaining within either the initial or the extended review period. If you do not receive a written response within the time limits described in this paragraph, your claim will be deemed denied and you will have the right to file an appeal.

If your claim for benefits is denied in whole or in part, the Claims Administrator will provide you with a written or electronic notification of the denial that will include:

- Specific reasons for the denial.
- Specific reference(s) to the Program provisions, or applicable law upon which the denial is based, where applicable.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.
- An explanation of the scientific or clinical judgment for the determination and how the terms of the Program were applied to your medical circumstances if the determination is based on medical necessity, experimental treatment or a similar exclusion or limit and that a copy of this explanation will be provided free of charge upon request.
- If applicable, a description of any additional information needed to make your claim acceptable and the reason the information is needed.
- A description of the Program's appeal procedures.
- A statement concerning your right to file a civil action under ERISA after the required review and all appeals have been completed.

IMPORTANT: As a requirement for receiving benefits from the Program, you must authorize AT&T or any Participating Company or any provider of documentation of a claim to furnish the Claims Administrator with any and all information and records relating to your claim. Such authorization will be treated as a waiver of all provisions of law forbidding such disclosure.

HOW TO APPEAL A DENIAL OF BENEFITS

KEY POINTS

- *You have 180 days after receipt of the denial notice to submit a written request to appeal the decision.*
- *Generally, you will receive a final determination regarding your appeal within 45 days of receipt of your appeal by the Claims Administrator.*
- *You may not file a lawsuit against the Plan until the appeal process has been exhausted.*

When You May File an Appeal

If your claim is denied in whole or in part (or you have **not** received a decision or a notice of extension within the applicable period) and you disagree with the decision, you may appeal the decision by filing a written request for review. You or your authorized representative must make the request for review within 180 days of receipt of the denial notice (or within 180 days after the review period has expired).

Who Decides Your Appeal

The Plan Administrator has delegated discretion and authority to decide appeals to the Claims Administrator. See the "Contact Information" section for information on how to contact the Claims Administrator. The Claims Administrator will have full and exclusive authority and discretion to grant and deny appeals under the Program. The decision of the Claims Administrator regarding any appeal will be final and conclusive.

How to Appeal a Denied Claim

If you or your authorized representative sends a written request for review of a denied claim, you or your representative has the right to:

- Send a written statement of the issues and any other comments along with any new or additional evidence or materials in support of your appeal. See the "Contact Information" section for the mailing address of the Claims Administrator.
- Upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.
- Request and receive, free of charge, documents that bear on your claim, such as any internal rule, guideline, protocol or other similar criterion relied on in denying your claim.

In your appeal, you should state as clearly and specifically as possible any facts and/or reasons why you believe the Claims Administrator's action is incorrect. You should also include any new or additional evidence or materials in support of your appeal that you wish the Claims Administrator to consider. Such evidence or material must be submitted along with your written statement at the time you file your appeal.

One or more qualified individual(s) who was not involved in the decision to deny your initial claim will be appointed to decide the appeal. This individual will decide the appeal based upon the evidence that was considered by the Claims Administrator; the issues, records and comments submitted by you; and such other evidence as the individual may independently discover.

If your claim was denied based upon medical judgment, the review will be done in consultation with a health care professional with appropriate expertise in the field and who was not involved in the initial determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. When you file your appeal, you consent to this referral and the sharing of pertinent information.

Your appeal may be decided entirely on the basis of evidence submitted in writing. You are not entitled to a hearing, nor do you have the right to present oral testimony or cross-examine authors of written evidence submitted. You will be provided with the identity of any medical or vocational experts whose advice the Program obtained in connection with denial of your appeal, without regard to whether the advice was relied upon in making the benefit determination.

Unless you are notified in writing that more time is needed, a review and decision on your appeal must be made within 45 days after your appeal is received. If special circumstances

require more time to consider your appeal, the Claims Administrator may take an additional 45 days to reach a decision, but you must be notified in writing that there will be a delay.

If your appeal is denied in whole or in part, the Claims Administrator will provide you with written or electronic notification that will contain:

- Specific reasons for the denial.
- Specific references to the Program provisions on which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.
- An explanation of the scientific or clinical judgment for the determination and how the terms of the Program were applied to your medical circumstances if the determination is based on medical necessity, experimental treatment or a similar exclusion or limit and that a copy of the explanation will be provided free of charge upon request.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.
- The following statement:

  "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Importance of Exhausting Administrative Remedies

If your appeal is denied, it is final and not subject to further review unless a court of competent jurisdiction determines that the Claims Administrator has abused its discretion in denying the claim.

If you wish to bring a legal action concerning your right to participate in the Program or your right to receive benefits under the Program, you must first go through the claim and appeal process described in this section. A legal action may not be filed until you have completed the claim and appeal process. Legal action involving the Program should be filed against the Plan.

You must file any legal action based on a denial of eligibility and/or benefits under the Program no later than five years after the date that the Claims Administrator, to whom authority has been assigned, denies your claim.

OVERPAYMENTS

The Program has the right to collect (at any time) any overpayment you receive by withholding your benefit payments from this Program, by deducting it from future wages, or by any other means, including bringing a civil action in court. Any overpayment by the Program may be recovered by withholding any benefit payable by the Program (for example, an overpayment while you are receiving Short-Term Disability Benefits may result in a reduction in your Vocational Rehabilitation Benefits or Long-Term Disability Benefits from the Program). If you, your attorney or other representative receives any funds that qualify as Offsets, you agree to place the funds in a separate, identifiable account. You also agree that the Program has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over

the funds to the extent that the Program has paid expenses related to that Illness or Injury. This means that you will be deemed to be in control of the funds.

SUBROGATION/RIGHT OF REIMBURSEMENT

Benefits under the Program will not be offset by benefits payable on account of subrogation and third-party liability.

ERISA RIGHTS OF PARTICIPANTS

KEY POINTS

- *ERISA is a federal law that provides certain rights and protection to all Program Participants.*
- *The persons who are responsible for the operation of the Program have a duty to act prudently and in the interest of the Participants and their beneficiaries.*
- *No one may fire or discriminate against you for exercising your ERISA rights.*

Your ERISA Rights

As a Participant in the Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Program, including collective bargaining agreements, insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Association (EBSA). There is no charge for this review.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Program, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies. Your written request must be directed to:

  AT&T Services, Inc.
  Attn: Plan Documents
  P.O. Box 132160
  Dallas, TX 75313-2160

- Receive a summary of the Program's annual financial report, if it is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each Participant with a copy of any required summary annual report (SAR).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) from the Program but do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and you have exhausted all applicable administrative remedies under the Program, you may file suit in state or federal court.

If it should happen that Program fiduciaries misuse the Program's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Program, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or at the address below:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

AT&T. AT&T Inc. a Delaware corporation, or its successors.

AT&T Group of Companies. AT&T Inc. and any other entity included with it as an "employer" as determined pursuant to Internal Revenue Code §414(b), (c), (m) and (o) and the regulations thereto.

Bargained Employee. Any employee whose job title and classification is included in a collective bargaining agreement between a Participating Company and a union that has agreed to the benefits provided under the Program.

Claims Administrator. The individual or entity delegated by the Plan Administrator to determine all claims and appeals for benefits under the Program. Currently, the Claims Administrator is Sedgwick Claims Management Services, Inc., which operates the AT&T Integrated Disability Service Center. See the "Contact Information" section for information on how to contact the AT&T Integrated Disability Service Center.

Company. Company means any or all of AT&T Inc., AT&T Services, Inc., or a Participating Company as indicated by the context.

Illness. Any disabling condition medically substantiated and treated by a Physician that renders an employee incapacitated from performing the duties of any job assigned by the Participating Company.

Injury. Any job and non-job-related trauma or damage to the physical person of an employee medically substantiated and treated by a Physician that renders an employee incapacitated from performing the duties of any job assigned by the Participating Company.

Leased Employee. An individual who is being paid by a company other than one of the AT&T Group of Companies and who is providing services to one or more of the AT&T Group of Companies in accordance with a contract that is between the company that is paying him and one or more of the AT&T Group of Companies. A Leased Employee is not eligible for coverage under the Program even if he is later determined (by judicial action or otherwise) to be a "common law employee" of one of the AT&T Group of Companies.

Leave of Absence. A leave of absence formally granted to an employee in accordance with rules established by his Participating Company.

Long-Term Disability Benefits. Long-Term Disability Benefits that are provided under the Program. See the "Your Long-Term Disability Benefits" section.

Medical Evidence. Objective medical information sufficient to show that the Participant is Disabled, as determined at the sole discretion of the Claims Administrator. Objective medical information includes, but is not limited to, results from diagnostic tools and examinations performed in accordance with the generally accepted principles of the health care profession. In general, a diagnosis that is based largely or entirely on self-reported symptoms will not be considered sufficient to support a finding of Disability. For example, reports of intense pain, standing alone, will be unlikely to support a finding of Disability, but reports of intense pain associated with an observable medical condition that typically produces intense pain could be sufficient.

Occasional Employee. You are an Occasional Employee if you are engaged by a Participating Company on a daily basis for a period of not more than three consecutive weeks, or for a cumulative total of not more than 30 days in any calendar year, regardless of the length of the daily or weekly assignments, or as otherwise defined in the collective bargaining agreement applicable to you. Occasional Employees are **not** eligible for the Program.

Participant. Either an Eligible Employee or former employee who is receiving benefits under the Program.

Physician. An individual duly licensed to prescribe and administer drugs and medicines or to perform surgery. Physician will also include:

- A duly licensed dentist operating within the scope of his/her license.
- A podiatrist operating within the scope of his/her license.
- A qualified vocational rehabilitation counselor operating within the scope of his/her license only when the use of such qualified vocational rehabilitation counselor is authorized by the Claims Administrator under the mandatory vocational rehabilitation provisions of the Program.
- Other Physicians under designated disability management programs authorized by the Plan Administrator when operating within the scope of his/her license.

Physician also includes, a licensed Physician, licensed psychiatrist or other licensed Physician including, but not limited to, a chiropractor or psychologist referred by a licensed Physician or licensed psychiatrist as part of an ongoing treatment plan of the licensed Physician or licensed psychiatrist.

Primary Social Security Benefits. The Primary Insurance Amount payable to the employee on account of disability in accordance with the United States Social Security Act that covers any portion of the period for which benefits are paid under the Program, and are payable on account of the employee's disability.

Regular Employee. You are a Regular Employee if your employment with a Participating Company is expected to be indefinite, as determined by your Participating Company, or as otherwise defined in the collective bargaining agreement applicable to you.

Short-Term Disability Benefits. Short-Term Disability Benefits that are provided under the Program. See the "Your Short-Term Disability Benefits" section.

Temporary Employee. You are a Temporary Employee if you are engaged by a Participating Company for a specific project or for a period of time for more than three consecutive weeks but not more than one year, with the definite understanding that your employment will terminate upon completion of the project or at the end of the period of time, whichever is first, or as otherwise defined in the collective bargaining agreement applicable to you.

Term Employee. You are a Term Employee if you are engaged by a Participating Company for a specific project or for a period of time for more than one year, but no more than three years, with the definite understanding that your employment will terminate upon completion of the project or at the end of the period of time, whichever is first, or as otherwise defined in the collective bargaining agreement applicable to you.

Vocational Rehabilitation Benefits. Vocational Rehabilitation Benefits that are provided under the Program. See the "Your Vocational Rehabilitation Benefits" section.

Workers' Compensation Benefits. All classes of benefits under the workers' compensation laws of any state, the District of Columbia, the United States government (e.g., benefits under the Longshore and Harbor Workers' Compensation Act) or any other jurisdiction in any country that requires payments to employees on a temporary or permanent basis in connection with injuries arising out of or in the course of employment, to replace or supplement income, or to compensate for diminished ability to compete in an open labor market, including but not limited to payments for temporary partial disability, temporary total disability, permanent partial disability, permanent total disability, vocational rehabilitation maintenance allowance and disability pension, whether liability for such payment has been determined by the court or administrative agency that determines liability for workers' compensation under the laws of such jurisdiction, or accepted voluntarily by the Participating Company or the Participating Company workers' compensation administrator or insurer.

OTHER PLAN INFORMATION

Other Plan Information	
Plan Name	AT&T Umbrella Benefit Plan No. 3
Program Name	AT&T Disability Income Program for Southwest Bargained Employees
Plan Number	603
Plan Sponsor/Employer Identification Number (EIN)	AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333** EIN 43-1301883

Other Plan Information	
Plan Administrator	AT&T Services, Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333**
Type of Administration	The Plan Administrator determines eligibility for coverage under the Program, that is, whether any particular individual is included in a group of employees that is covered by the Program. The Claims Administrator has been delegated the complete discretionary fiduciary responsibility for all disability determinations by the Plan Administrator to determine whether a particular Eligible Employee who has filed a claim for benefits is entitled to benefits under the Program, to determine whether a claim was properly decided, and to conclusively interpret the terms and provisions of the Program. Such determinations and interpretations shall be final and conclusive. The Plan Administrator (or, in matters delegated to third parties, the third-party that has been so delegated) will have sole discretion to interpret the Program, including, but not limited to, interpretation of the terms of the Program, determinations of coverage and eligibility for benefits, and determination of all relevant factual matters. Any determination made by the Plan Administrator or any delegated third party will not be overturned unless it is determined to be arbitrary and capricious.
Agent for Service of Legal Process	Process in legal actions in which the Plan is a party should be served on the Plan at the following Address CT Corporation 350 N. St. Paul St. Dallas, TX 75201 Service of legal process also may be made upon a Trustee or the Plan Administrator.
Type of Plan	The Plan is an employee welfare benefit plan.
Plan Year	Jan. 1 through Dec. 31
Trustee	AT&T Voluntary Employee Beneficiary Association Trust Frost National Bank 100 W. Houston St. P.O. Box 2950 San Antonio, TX 78299
Plan Funding and Contributions	The Program is funded by a trust. Program costs are funded by periodic, non-reversionary Company contributions determined by the Program's actuaries for the purpose of funding Program benefits and maintaining appropriate reserves. Contributions are transferred to the Trust, which is established exclusively for approved Plan purposes. Benefits under the Program are paid or reimbursed by the Trust. Benefits paid in excess of IRS limits are funded by the general assets of your Participating Company. No benefits provided under the Program are provided by insurance.
Collectively Bargained Plan	With respect to certain Eligible Employees, the Program is maintained pursuant to one or more collective bargaining agreements. A copy of the collective bargaining agreement(s) may be obtained by Participants and beneficiaries whose rights are governed by such collective bargaining agreement upon written request to the Plan Administrator and also is available for examination by Participants and beneficiaries as specified under Department of Labor Regulations Section 2520.104b-30.

Amendment or Termination of the Program

The Program is adopted with the intention that it will be continued for the benefit of present and future employees of Participating Companies; however, the right is reserved by the Plan Sponsor to terminate, amend, change or modify the Program retroactively or prospectively, in whole or in part at any time or for any reason, including changes in any and all of the benefits herein provided. Further, any Participating Company may terminate its participation in the Program at any time and for any reason. Such termination, amendment, change or modification of the Program, or termination of any Participating Company's participation in the Program may cause employees to lose all or a portion of their benefits or eligibility under the Program but will not affect the right of any employee to receive benefits for which he has already become entitled under the Program. Not affecting an employee's right to any benefit for which he has already become entitled under the Program means that the employee who is actually receiving payments would be entitled to continue receiving his disability benefits through the date of the Program's termination or change until such benefits would otherwise cease. This does not mean that an employee will acquire a lifetime right to any Program benefit, to eligibility for coverage under the Program or to the continuation of the Program merely by reason of the fact that such benefit or the Program is in existence at any time during the employee's employment. The Program will comply with all requirements of applicable law and will be amended, if necessary, in order to satisfy any such requirements.

In the event of termination of the Program, you will be entitled to the benefits in effect at the time of any event that requires payment of such benefits.

Although a certain Plan or one of its Programs may be in effect during your employment or at the time of your retirement, it does not mean that you or any other employee or beneficiary will have:

- A lifetime right to any benefits under the Plan or Program.
- Eligibility for coverage under any such Plan or Program.
- Guaranteed continuation of any such Plan or Program.
- Coverage at Company expense or based upon a previously identified contribution schedule.

Limitations on Rights

Participation in the Program does not give you a right to remain employed with your Participating Company or any AT&T-affiliated Company.

Assignment and Nonalienation

Except as otherwise required by law, benefits provided under the Program may not be assigned or alienated. This means that you may not sell, assign, pledge or otherwise transfer benefits under the Program before the benefits are distributed to you, nor are your Program benefits subject to attachment, garnishment, execution or encumbrance of any kind prior to distribution to you.

Facility of Payment

If benefits under this Program have been paid under any other plan or program, the Plan has the right to pay any amounts, as determined by the Claims Administrator, to such other plan or program, or any other organization making those other payments. Such payment by the Plan will discharge the Plan from any liability for such benefits under the Program.

CONTACT INFORMATION

Contact Information	
Claims Administrator	
Name	AT&T Integrated Disability Service Center
Type	Claim initiation and appeals for Disability Programs
Claims Administrator Contact Numbers	
Domestic Telephone Number	**866-276-2278**
Claims Administrator Hours of Operation	
Hours of Operation	**Service Center:** Monday through Friday from 7 a.m. to 7 p.m. Central time
Claims Administrator Mailing Address	
Claims	
Claims Regular	AT&T Integrated Disability Service Center P.O. Box 14627 Lexington, KY 40512-4627 **866-224-4627** (fax)
Appeals	
Appeals Regular	AT&T Integrated Disability Service Center Quality Review Unit P.O. Box 14626 Lexington, KY 40512-4626 **866-856-5065** (fax)

Beneficiary Designation Administrator

Fidelity Service Center

For all active and inactive employees and former employees:

- Call the Fidelity Service Center to report a death or ask questions about beneficiary designation forms.
- Visit **www.netbenefits.fidelity.com** to review and print or request an AT&T Beneficiary Designation Form.
- You may also call the Fidelity Service Center to request an AT&T Beneficiary Designation Form.
- Return completed AT&T Beneficiary Designation Forms to the mailing address below.

Fidelity Service Center
P.O. Box 770003
Cincinnati, OH 45277-0088

→ **www.netbenefits.fidelity.com**

800-416-2363

Dial your country's toll-free AT&T Direct access number then enter **800-416-2363** (international).

888-343-0860 (hearing-impaired)

Monday through Friday from 7:30 a.m. to 11 p.m. Central time.

The automated voice response system is available 24 hours a day, seven days a week.

You will need your Fidelity Service Center PIN and Social Security number/customer ID when you access the automated voice response system or call to speak to a service associate.

If you wish to file a written claim or a written appeal of a denied beneficiary form, use the following mailing address:

Beneficiary Designation Administrator
Personnel Center
P.O. Box 770003
Cincinnati, OH 45277-0072

INFORMATION CHANGES AND OTHER COMMON RESOURCES

It's important to keep your work and home addresses current. The majority of your benefits, payroll or similar information is sent to work or home. Please include any room, cubicle, apartment or suite number that will help make mail-routing more efficient.

Active Employee Address and Telephone Number Changes

For employees with access to the employee intranet:

Home and **work** address updates:

- Go to **insider.web.att.com.**
- Click on OneStop (**onestop.web.att.com**) and select eLink (eCORP) under Tools & Resources.
- Enter your AT&T user ID and password for the AT&T Global Logon. (If you do not know your password, please follow the instructions on the screen.)
- Once logged on, click OK.
- On the eCORP home page, click on Employee Services.
- **Note**: Please be sure the far right-hand scroll bar is all the way to the top.
- Select Personal Information.
- Select Maintain Addresses and Telephone Numbers.
- To update your home address, select "Edit" at the bottom of the Permanent Residence box, make any necessary changes, and click Save.
- To update your work address, select "Edit" at the bottom of the Cubicle/Office box, make any necessary changes, and click Save.

For employees without access to the employee intranet:

Contact your supervisor or eLink assistant.

Former Employees Home Address Changes

Call the Fidelity Service Center to change your address.

Telephone numbers and dialing instructions:

800-416-2363

888-343-0860 (hearing-impaired)

Dial your country's toll-free AT&T Direct access number, then enter **800-416-2363** (international)

Hours of operation:

Monday through Friday from 7:30 a.m. to 11 p.m. Central time.

You will need your Fidelity Service Center PIN and Social Security number/customer ID when you call to speak to a service associate.

IMPORTANT: The instructions are also for recipients of Long-Term Disability Benefits and employees on a Leave of Absence.

If you are not eligible to receive a pension or savings plan benefit, or have already received your entire pension and savings plan benefits in a lump sum and are not eligible for a retiree death benefit from your pension plan, call the AT&T Benefits Center at **877-722-0020** to update your home address.

AT&T Benefits Intranet and Internet Access
Your Money Matters section of OneStop (Active Employees only) Go to the Your Money Matters section of OneStop at **onestop.web.att.com**.
Your Money Matters section of access.att.com (Active Employees from home) Go to the Your Money Matters section of **access.att.com** (AT&T's secure Internet site) for benefits information at home.
Your Benefits section of access.att.com (Former Employees from home) Go to the Your Benefits section of **access.att.com** (AT&T's secure Internet site) for benefits information at home.

APPENDIX A: PARTICIPATING COMPANIES AND APPLICABLE BARGAINING AGREEMENTS

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
SBCSI - CWA District 6	AT&T Services, Inc. SBCSI	Bargained	AT&T Southwest Core Contract - CWA District 6
SMSI - CWA District 6	AT&T Messaging, LLC SMSI	Bargained All Active Employees moved to AT&T Services, Inc. Sep. 18, 2011.	AT&T Messaging, LLC - CWA District 6
SWBT - CWA District 6	Southwestern Bell Telephone Company SWBT	Bargained	AT&T Southwest Core Contract - CWA District 6

Amendment

The AT&T Disability Income Program for Bargained Employees and the AT&T Disability Income Program for Southwest Bargained Employees of the AT&T Umbrella Benefit Plan No. 3 are hereby amended, effective January 1, 2015, as provided in the attached summary of material modifications at the NIN 78-33532.

DQM 12/12/14

William A. Blase
Senior Executive Vice President – Human Resources
AT&T Inc.

12/12/14
Date

Summary of Material Modifications

IMPORTANT BENEFITS INFORMATION

AT&T Disability Income Programs

This is a summary of material modifications (SMM) for the AT&T Disability Income Program, the AT&T Disability Income Program for Bargained Employees and the AT&T Disability Income Program for Southwest Bargained Employees (collectively, the Programs) Summary Plan Descriptions (SPDs), component Programs of the AT&T Umbrella Benefits Plan No. 3 (Plan) and should be used with the SPDs dated September 2014.

Please keep this document for future reference.

NIN 78-33532

IMPORTANT INFORMATION

In all cases, the official Plan document, which consists of the summary plan descriptions (SPDs) for the AT&T Disability Income Program, the AT&T Disability Income Program for Bargained Employees and the AT&T Disability Income Program for Southwest Bargained Employees (collectively, the Programs) and all of the summary of material modifications (SMMs), along with the Plan document for the AT&T Umbrella Benefit Plan No. 3, governs and is the final authority on the terms of the Programs. AT&T Inc. reserves the right to terminate or amend any and all of its employee benefit plans or programs at any time for any reason. Participation in the Programs is neither a contract nor a guarantee of future employment.

What is this document?

This document is an SMM and describes recent changes to the respective SPDs for the Programs.

Este documento contiene un resumen de las modificaciones materiales (SMM), en ingles. Si usted tiene dificultad que entiende este SMM, entre en contacto con por favor el Fidelity Service Center a **800-416-2363**.

What action do I need to take?

You should review this SMM and your SPD in their entirety so that you can understand the details of the changes to the Programs. No other action is necessary.

How do I use this document?

Keep this SMM with your SPD and all other SMMs so you can refer to them in the future. They are your primary resource for your questions about the Programs.

Questions?

If you have questions regarding information in this SMM or other questions about the Programs, call the applicable administrator listed in the "For More Information" section of this SMM.

INTRODUCTION

The "Final Unpaid Benefits Under the Program" and "Definition" sections of the Programs' SPDs have been updated to reflect certain changes made with respect to how benefits under the Programs will be paid if you die.

FINAL UNPAID BENEFITS UNDER THE PROGRAM

If you die, benefits under the Program will be paid through the date of your death to your designated Beneficiary. You may designate a Beneficiary using the Beneficiary Designation Form and process established by the Beneficiary Designation Administrator. For a copy of the Beneficiary Designation Form, call the Beneficiary Designation Administrator, or access the form at **www.netbenefits.com/att**.

If you have not designated a Beneficiary or if all of your designated Beneficiary(ies) have died before your death, benefits under the Program will be paid as follows:

If...	Then All Proceeds From Each Program in Which You Participated Will Be Distributed to Your...
You are married...	Spouse
You have a Legally Recognized Partner...	Legally Recognized Partner
You are not survived* by a Spouse or Legally Recognized Partner...	Surviving* Child** or Children** in equal amounts***
You are not survived* by a Spouse, Legally Recognized Partner or Child**...	Surviving* parent** or parents** in equal amounts***
You are not survived* by a Spouse, Legally Recognized Partner, Child** or parent**...	Surviving* sibling** or siblings** (including half blood) in equal amounts***
You are not survived* by a Spouse, Legally Recognized Partner, Child**, parent** or sibling**...	Your estate in accordance with the applicable laws of the state in which you resided immediately before your death that govern succession to property owned by you at death, unless the Program Administrator determines, in its sole discretion, that it is more appropriate to apply similar law of another state under the circumstances.

**Your Beneficiary must survive for at least 120 hours after your death to be entitled to your benefits under the Program. A Beneficiary not meeting the survival requirement is treated as if he or she died before your death. If the time of your death or the death of your Beneficiary cannot be determined, or if it cannot be established that a Beneficiary survived you by 120 hours, it will be deemed that the Beneficiary failed to survive you, and your benefits under the Program will be distributed as if the Beneficiary had predeceased you.*

***The terms "Child," "Children," "parent" or "sibling" refer to individuals who are related by birth or by adoption and not through marriage.*

****Your benefits under the Program will be distributed on a per capita basis and not on a per stirpes basis, which means that all surviving individuals in one of the groups listed in this table will share your benefits under the Program on an equal basis, and no benefits under the Program will pass to the descendants of a deceased member of the group.*

Special Circumstances

The effect that certain special circumstances have on your Beneficiary Designation is detailed as described in the table below:

If...	Then...
Your Beneficiary is your Spouse and if you get divorced or have your marriage annulled...	Your Beneficiary Designation for your Spouse is revoked as of the date of the dissolution or annulment of your marriage. Your ex-Spouse's share or right to a share will be distributed as if he or she died before you.
You want to make your ex-Spouse a valid Beneficiary...	You must complete a new Beneficiary Designation form(s) after the date your marriage was dissolved or annulled and, if you remarried, have the written consent of your new Spouse.
Your surviving* Beneficiary disclaims or waives part or all of his or her rights to your Program benefits...	That individual or entity's waived portion will be distributed as if that Beneficiary died before you.
You are single (including widows and widowers), have a Form on file and later marry or remarry...	Your new Spouse may not automatically become a Beneficiary. Depending upon the laws of the state in which you live, your Beneficiary Designation(s) on file may remain in effect unless a new Beneficiary Designation Form is submitted. If you wish your new Spouse to be a Beneficiary, it is best to submit a new Beneficiary Designation Form.
Your Beneficiary Designation was made under duress, undue influence or by reason of fraud, or your Beneficiary caused or participated in causing your death...	The Program Administrator, in its sole discretion, will determine, on the basis of all the facts and circumstances, whether it is likely that a civil jury would disqualify that Beneficiary from receiving any part of your Program benefits. If a Program Administrator makes this determination, that Beneficiary's portion will be deposited with the court for distribution in accordance with the Program. The Program Administrator will have no further liability to anyone with respect to those Program benefits. The decision of the Program Administrator is binding.

**Your Beneficiary must survive for at least 120 hours after your death to be entitled to your Program benefits. A Beneficiary not meeting the survival requirement is treated as if he or she died before your death. If the time of your death or the death of your Beneficiary cannot be determined, or if it cannot be established that a Beneficiary survived you by 120 hours, it will be deemed that the Beneficiary failed to survive you, and the Program benefits will be distributed as if the Beneficiary had predeceased you.*

DEFINITIONS

Beneficiary. The individual(s), trust, estate or other legal entity capable of owning property designated by you in a Beneficiary Designation Form to receive, in the event of your death, any unpaid benefits due to you under the Program.

Beneficiary Designation. A writing prepared by you in which you designate one or more Beneficiaries to receive, in the event of your death, any unpaid benefits due to you under the Program.

Beneficiary Designation Administrator. The individual or entity appointed by AT&T to administer death-claim processing and Beneficiary Designations.

Beneficiary Designation Form. A form developed for use in designating Beneficiaries to receive, in the event of your death, any unpaid benefits due to you under the Program.

FOR MORE INFORMATION

If you have any questions regarding the information provided in this SMM, contact the Fidelity Service Center.

Beneficiary Designation Administrator
Fidelity Service Center
For all active and inactive employees and former employees: • Call the Fidelity Service Center to report a death or ask questions about Beneficiary Designation Forms. • Visit **www.netbenefits.fidelity.com** to review and print or request an AT&T Beneficiary Designation Form. • You may also call the Fidelity Service Center to request an AT&T Beneficiary Designation Form. • Return completed AT&T Beneficiary Designation Forms to the mailing address below. Fidelity Service Center P.O. Box 770003 Cincinnati, OH 45277-0088 → **www.netbenefits.com/att** ☎ **800-416-2363** ☎ Dial your country's toll-free AT&T Direct access number, then enter **800-416-2363** (international). ☎ **888-343-0860** (hearing-impaired) Monday through Friday from 7:30 a.m. to 11 p.m. Central time. The automated voice response system is available 24 hours a day, seven days a week. You will need your Fidelity Service Center PIN and Social Security number/customer ID when you access the automated voice response system or call to speak to a service associate. If you wish to file a written claim or a written appeal of a denied Beneficiary Designation Form, use the following mailing address: Beneficiary Designation Administrator Personnel Center P.O. Box 770003 Cincinnati, OH 45277-0072

Summary of Material Modifications

IMPORTANT BENEFITS INFORMATION

Changes to AT&T Health and Welfare Plans for DIRECTV Bargained Employees and Eligible Former DIRECTV Bargained Employees covered by CWA Collective Bargaining Agreements

This is a Summary of Material Modifications (SMM) to the Summary Plan Descriptions (SPD) for the AT&T health and welfare plans listed in *Appendix A* of this SMM.

DISTRIBUTION: Distributed to all DIRECTV Bargained Employees and Eligible Former DIRECTV Bargained Employees covered under a CWA collective bargaining agreement.

NIN: 78-40457

IMPORTANT INFORMATION

This Summary of Material Modifications (SMM) was written for easy readability, so, it may contain generalizations and informal terms rather than precise legal terms. Also, this SMM only summarizes benefits; individual situations may vary. In all cases, the official documents for the affected Plans (including component Programs) govern and are the final authority on the terms of the Plans. If there are discrepancies between the information in this SMM and the Plan, the Plan document will control. AT&T Inc. reserves the right to terminate or amend any and all of its employee benefit plans or programs at any time for any reason, including with respect to any "DIRECTV Bargained Employee" (as the term is defined below). Participation in the Plans is neither a contract nor a guarantee of future employment.

What Is This Document?

This is an SMM and describes a change in eligibility and in some cases benefits for the affected Plans. An SMM is legally required when material changes are made to the Plans.

What Action Do I Need to Take?

You should review this SMM and your Summary Plan Descriptions (SPDs) in their entirety, so you can understand the details of your benefits and take any required action. Keep this SMM with your SPDs and all other SMMs for future reference. They are your primary resource for questions about your benefits.

Why Did I Receive This Document?

You are receiving this SMM because the Plan's records indicate that you are a DIRECTV Bargained Employee (as the term is defined below) and are eligible to participate in the Programs listed in *Appendix A* effective June 1, 2017.

Questions?

If you have questions about information in this SMM, your SPD or about the Programs, call the administrator listed in the "For More Information" section of this SMM.

Si usted tiene alguna dificultad en entender este documento, por favor póngase en contacto con el administrador que aparece en la sección que se titula "For More Information."

INTRODUCTION

This SMM is an update to the Summary Plan Descriptions (SPDs) for the AT&T health and welfare plans listed in *Appendix A* of this SMM. On July 24, 2015, AT&T Inc. (AT&T) purchased DIRECTV. Effective June 1, 2017, DIRECTV Bargained Employees and their dependents will be eligible to participate in AT&T health and welfare benefit plans as described in this SMM.

For the purposes of this SMM:

1. "DIRECTV Bargained Employee" means a current employee who is covered by a CWA collective bargaining agreement referred to in *Appendix B* – Participating Companies and Associated Bargaining Units.

2. "Eligible Former DIRECTV Bargained Employee" means a DIRECTV Bargained Employee who terminates employment during the term of the current CWA Collective Bargaining Agreement and who meets the applicable requirements to be eligible for post-retirement benefits.

NEW PARTICIPATING COMPANIES AND BARGAINING GROUPS

The Participating Companies and bargaining groups listed in *Appendix B* are added to the AT&T Plans and Programs listed in *Appendix A* effective June 1, 2017.

AT&T CAREPLUS PROGRAM

DIRECTV Bargained Employees will be eligible for a mid-year enrollment opportunity in April 2017, for participation in the AT&T CarePlus Program, for coverage to be effective June 1, 2017.

AT&T DISABILITY PROGRAMS

Effective June 1, 2017, DIRECTV Bargained Employees who are actively at work are no longer eligible to participate in the AT&T Disability Income Program and will be eligible for participation in the Disability Programs as provided below based on bargaining group:

DIRECTV CWA Call Center in the Southeast Region District 3 - Black

- The employee will be covered under the AT&T Mobility Disability Benefits Program.

DIRECTV CWA Call Center in the Southwest Region District 6 - Purple

- Employees with a Term of Employment on or before December 31, 2016 will be covered under the AT&T Mobility Disability Benefits Program for Southwest Bargained Employees. Employees with a Term of Employment on or after January 1, 2017 will be covered under the AT&T Disability Income Program.

DIRECTV CWA Call Center in the Mobility Districts 1, 2-13, 4, 7, and 9 - Orange

- CWA Districts 1, 2- 13, 4, 7, 9 AT&T Mobility Services LLC employees will be covered under the AT&T Mobility Disability Benefits Program.

    - Special Rules for Certain Bargained Employees

        - If the employee is classified in the Personnel Sub-area as NEGL (Northeast Great Lakes Sales Region), then the employee is eligible for the AT&T Mobility Disability Benefits Program for Southwest Bargained Employees.

            - All other payroll Bargained Employees under this contract will be eligible for the AT&T Mobility Disability Benefits Program.

DIRECTV CWA Technicians, Warehouse and Clerical in the Midwest Region

- Employees with a Term of Employment on or before June 26, 2015 will be covered under the AT&T Midwest Disability Benefits Program. Employees with the Term of Employment on or after June 27, 2015 will be covered under the AT&T Disability Income Program.

DIRECTV CWA Technicians, Warehouse and Clerical in the Southeast Region

- Employees with a Term of Employment on or before December 4, 2015 will be covered under the AT&T Southeast Disability Benefits Program. Employees with a Term of Employment on or after December 5, 2015 will be covered under the AT&T Disability Income Program.

DIRECTV CWA Technicians, Warehouse and Clerical in the Southwest Region

- Employees with a Term of Employment on or before April 5, 2013 will be covered under the AT&T Disability Income Program for Southwest Bargained Employees. Employees with a Term of Employment on or after April 6, 2013 will be covered under the AT&T Disability Income Program.

Former DIRECTV CWA Technical Support Employees - NIC

- The employee will be covered under the AT&T Disability Income Program (NIC provisions).

DIRECTV CWA Out of Region Techs

- Employees with a Term of Employment on or before June 26, 2015 will be covered under the Legacy AT&T Disability Benefits Program. Employees with a Term of Employment on or after June 27, 2015 will be covered under the AT&T Disability Income Program.

AT&T FLEXIBLE SPENDING ACCOUNT PLAN

DIRECTV Bargained Employees will participate in the AT&T Flexible Spending Account Plan and will have the contributions for health and welfare benefits in which they have enrolled deducted pre-tax, unless post-tax deductions are specifically elected. Participants may elect to contribute to a Healthcare FSA or Dependent care FSA based on the limits identified in the table below with respect to their applicable bargaining agreements:

Eligible Employee Group	Characterization of Employees Eligible to Enroll	Eligibility Waiting Period	Health Care FSA Contribution Limits	Dependent Care FSA Contribution Limits
SBCSI - CWA District 1, 2-13, 4, 7, 9 **SBCSI - CWA District 3** **SBCSI - CWA District 6**	Regular Full-Time Regular Part-Time	First of the month following completion of one month NCS	Minimum = $100 Maximum = $2,550	Minimum = $100 Maximum = $5,000
DTV – CWA District 3	Regular Full-Time Regular Part-Time	None	Minimum = $100 Maximum = $2,550	Minimum = $100 Maximum = $5,000
DTV – CWA District 4	Regular Full-Time Regular Part-Time Regular Limited Term Full-Time Regular Limited Term Part-Time	None	Minimum = $100 Maximum = $2,550	Minimum = $100 Maximum = $5,000

Eligible Employee Group	Characterization of Employees Eligible to Enroll	Eligibility Waiting Period	Health Care FSA Contribution Limits	Dependent Care FSA Contribution Limits
DTV - CWA	Regular Full-Time Regular Part-Time	None	Minimum = $100 Maximum = $2,550	Minimum = $100 Maximum = $5,000
DTV - CWA District 6	Regular Full-Time Regular Part-Time Temp Full-Time Temp Part-Time	None	Minimum = $100 Maximum = $2,500	Minimum = $100 Maximum = $5,000
DTV - CWA - NIC Tier 2	Regular Full-Time Regular Part-Time Temp Full-Time Temp Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,500	Minimum = $100 Maximum = $5,000

ACTIVE LIFE INSURANCE

The "Eligible Dependent Exceptions" section of the AT&T Group Life Insurance Program for Active Employees (NIN 78-36217) is updated to add the following at the end of the section:

DIRECTV Dependents

All DIRECTV Bargained Employees and their dependents who were eligible to enroll in the DIRECTV Welfare Benefit Plan ("DIRECTV Plan") on Dec. 31, 2016, are eligible to enroll in the AT&T Group Life Insurance Program for Active Employees, effective Jan. 1, 2017. Dependents who are enrolled in the DIRECTV Plan on Dec. 31, 2016 will not be required to complete the Dependent Eligibility Verification process described in the SPD for the AT&T Group Life Insurance Program for Active Employees as a condition of their 2017 enrollment in the AT&T Programs.

The following "Eligible Dependent Exceptions" provision is added to the AT&T Group Life Insurance Program for Active Employees to allow coverage for the dependents of DIRECTV Bargained Employees, effective Jan. 1, 2017. In addition, domestic partners enrolled in the DIRECTV Plan on Dec. 31, 2016 will be eligible as a Legally Recognized Partner until Dec. 31, 2017, at which time the AT&T Legally Recognized Partner definition will apply. It is the intent of these provisions that dependents eligible and enrolled for life insurance coverage in the DIRECTV Plan will continue to be eligible under the AT&T Group Life Insurance Program for Active Employees, through Plan Year 2017, provided the qualifying dependent relationship continues and subject to the maximum age limits under the applicable programs. Eligibility will end for dependents of a DIRECTV Bargained Employee if the dependent relationship ends, for example upon divorce or the termination of a legal guardianship.

During 2017, all dependents of a DIRECTV Bargained Employee for whom coverage is elected will be required to complete the Dependent Eligibility Verification process as provided in the AT&T Group Life Insurance Program for Active Employees. The definition of Eligible Dependent, without regard to this Eligible Dependent Exception, will apply for purposes of the Dependent Eligibility Verification. Coverage for dependents whose eligibility is not verified will end as of Dec. 31, 2017.

Any dependents of a DIRECTV Bargained Employee covered added to life insurance coverage on or after Jan. 1, 2017 will be required to meet the definition of Eligible Dependent in the AT&T

Group Life Insurance Program for Active Employees without regard to this Eligible Dependent Exception and complete Dependent Eligibility Verification at the time of enrollment.

AT&T MEDICAL PROGRAM

DIRECTV Bargained Employees will no longer be eligible to participate in the AT&T Medical Program effective May 31, 2017. Effective June 1, 2017, DIRECTV Bargained Employees are eligible to participate in AT&T sponsored medical programs as provided in the applicable collective bargaining agreement.

FOR MORE INFORMATION

If you have any questions regarding the information provided in this SMM, contact the AT&T Benefits Center.

Who	How to Contact
AT&T Benefits Center Eligibility and Enrollment Vendor	**877-722-0020 (domestic)** **1-847-883-0866 (International)** Customer service representatives are available Monday through Friday, 7 a.m. to 7 p.m. Central time. **att.com/benefitscenter**

APPENDIX A

This appendix lists the affected Plans (including component Programs) and Policies to which this SMM applies.

AT&T Umbrella Benefit Plan No. 1

Life Insurance Programs

AT&T Eligible Former Bargained Employee Group Life Insurance Program

Other Programs

AT&T Eligible Former Employee CarePlus – A Supplemental Benefit Program

AT&T Umbrella Benefit Plan No. 2

Life Insurance Programs

AT&T Dependent Group Life Insurance Program

AT&T Special AD&D Insurance Program

AT&T Supplementary Group Life Insurance Program

AT&T Umbrella Benefit Plan No. 3

Life Insurance Programs

AT&T Group Life Insurance Program for Active Employees

Disability Programs

AT&T Disability Income Program

AT&T Midwest Disability Benefits Program

AT&T Mobility Disability Benefits Program

AT&T Mobility Disability Benefits Program for Southwest Bargained Employees

AT&T Disability Income Program for Southwest Bargained Employees

AT&T Southeast Disability Benefits Program

Legacy AT&T Disability Benefits Program

Other Programs

AT&T CarePlus – A Supplemental Benefit Program

Flexible Spending Account Plan

AT&T Flexible Spending Account Plan

APPENDIX B – PARTICIPATING COMPANIES AND ASSOCIATED BARGAINING UNITS

This appendix lists the affected Participating Company and Bargaining Units that are added to the Programs listed in *Appendix A*.

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
DTV - CWA District 6	DIRECTV, LLC DTV	Bargained - Effective June 1, 2017	AT&T Southwest Core Contract - CWA District 6
DTV - CWA District 4	DIRECTV, LLC DTV	Bargained - Effective June 1, 2017	AT&T Midwest Core Contract - CWA District 4
DTV - CWA District 3	DIRECTV, LLC DTV	Bargained - Effective June 1, 2017	AT&T Southeast Core Contract - CWA District 3
DTV - CWA	DIRECTV, LLC DTV	Bargained	AT&T Corp. Core Contract - CWA
DTV - CWA - NIC Tier 2	DIRECTV, LLC DTV	Bargained - Effective June 1, 2017	AT&T Services, Inc., National Internet Contract - Tier 2 - CWA
SBCSI - CWA District 3	AT&T Services, Inc. SBCSI	Bargained - DTV Customer Assistants - effective June 1, 2017	AT&T Mobility Services LLC - CWA District 3 (Black Contract)
SBCSI - CWA District 6	AT&T Services, Inc. SBCSI	Bargained - DTV Customer Assistants - effective June 1, 2017	AT&T Mobility Services LLC - CWA District 6 (Purple Contract)
SBCSI - CWA Districts 1, 2-13, 4, 7, 9	AT&T Services, Inc. SBCSI	Bargained - DTV Customer Assistants - effective June 1, 2017	AT&T Mobility Services LLC - CWA Districts 1, 2-13, 4, 7, 9 (Orange Contract)

NOTES

NOTES

AT&T Inc.
and Participating Companies

Human Resources-Benefits
P.O. Box 460582
St. Louis, MO 63146

Forwarding Service Requested

NIN: 78-40457

EXHIBIT
B

Olds tee02 M6

Social Security Administration
Retirement, Survivors, and Disability Insurance
Notice of Award

Mid-America Program
Service Center
601 East Twelfth Street
Kansas City, Missouri 64106-2817
Date: January 15, 2018
Claim Number: [redacted]

0000669 00006377 2 MB 0.423 0110MACTR6PI T32 P6
SPENCER L DAVIS
2811 TIMBERCREEK DR
BRYANT AR 72022-8102

We are writing to let you know that you are entitled to monthly disability benefits from Social Security beginning April 2015.

Your Benefits

The following chart shows your benefit amount(s) before any deductions or rounding. The amount you actually receive may differ from your full benefit amount. When we figure how much to pay you, we must deduct certain amounts, such as Medicare premiums and worker's compensation offset. We must also round down to the nearest dollar.

Beginning Date	Benefit Amount	Reason
April 2015	$ 1,967.20	Entitlement began
December 2016	$ 1,973.10	Cost of living adjustment
December 2017	$ 2,012.50	Cost of living adjustment

We will continue to withhold money for voluntary Federal tax withholding as you requested.

What We Will Pay

We pay Social Security benefits for a given month in the next month. For example, we pay Social Security benefits for March in April.

- Your first payment is for $1,569.60.
- This is the money you are due through January 2018.
- After that, you will receive $1,690.20 on or about the third of each month.

SEE NEXT PAGE

[redacted]

Your monthly payments will go to the financial institution you selected.

Other Information

We are [redacted] of this notice to your representative.

Information About Medicare

You are entitled to hospital insurance under Medicare beginning April 2017.

You are entitled to medical insurance under Medicare beginning January 2018.

We did not give you earlier medical insurance because we did not process it timely. If you want to have these benefits earlier, you can choose medical insurance benefits beginning April 2017. If you want this benefit to start earlier, you must do the following things within 60 days after the date of this notice:

- tell us in writing that you want the medical insurance benefits beginning April 2017;
- pay us $1,206.00 (this covers the premiums due from April 2017 through December 2017); or,
- tell us we can withhold this amount from the check.

If you want the benefits beginning April 2017 but find it hard to pay the premium amount in a lump sum, ask us about other ways to pay the money.

We charge a monthly premium for your medical insurance. The rates are shown below:

Beginning Date	Amount
January 2018	$ 134.00

We are taking medical insurance premiums due through February 2018 out of the check you will receive around February 2, 2018. These premiums total $268.00. We will deduct medical insurance premiums 1 month in advance.

We are deducting past-due premiums from your check.

SEE NEXT PAGE

[redacted]

[redacted]

Medicare Prescription Drug Plan Enrollment

Now that you are eligible for Medicare, you can enroll in a Medicare prescription drug plan (Part D).

To learn more about the Medicare prescription drug plans and when you can enroll, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). Medicare also can tell you about agencies in your area that can help you choose your prescription drug coverage.

If you have limited income and resources, we encourage you to apply for the extra help that is available to assist with Medicare prescription drug costs. The extra help can pay the monthly premiums, annual deductibles and prescription co-payments. To learn more or apply, please visit www.socialsecurity.gov, call 1-800-772-1213 (TTY 1-800-325-0778) or visit the nearest Social Security office.

Information About Representative's Fees

We have approved the fee agreement between you and your representative.

We are paying the representative from the benefits we withheld. Therefore, we must collect a service charge from him or her. The service charge is 6.3 percent of the fee amount we pay, but not more than $93, which is the most we can collect in each case under the law. We will subtract the service charge from the amount payable to the representative.

The representative cannot ask you to pay for the service charge. If the representative disagrees with the amount of the service charge, he or she must write to the address shown at the top of this letter. The representative must tell us why he or she disagrees within 15 days from the day he or she gets this letter.

How to Ask Us to Review the Fee

You, the representative or the person who decided your case can ask us to review the amount of the fee we say the representative can charge.

If you think the amount of the fee is too high, write us within 15 days from the day you get this letter. Tell us that you disagree with the amount of the fee and give your reasons. Send your request to this address:

Social Security Administration
Office of Hearings Operations
Attorney Fee Branch
5107 Leesburg Pike
Falls Church, Virginia 22041-3255

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"1000669" "0302SSKC2000009" C1K6P1 181110 00000001000000

[redacted]

The representative also has 15 days to write us if he or she thinks the amount of the fee is too low.

If we do not hear from you or the representative, we will assume you both agree with the amount of the fee shown.

Information About Past-Due Benefits Withheld To Pay A Representative

Your past-due benefits are $50,704.00 for April 2015 through November 2017. Your family's past-due benefits are $23,332.00 for April 2015 through November 2017. Under the fee agreement, the lawyer cannot charge you and your family more than $6,000.00 for his or her work. The amount of the fee does not include any out-of-pocket expenses (for example, costs to get copies of doctors' or hospitals' reports). This is a matter between you and the lawyer.

Based on the law, we must withhold part of past-due benefits to pay an appointed representative. We cannot withhold more than 25 percent of past-due benefits to pay an authorized fee. We withheld $6,000.00 from your past-due benefits to pay the representative.

Other Social Security Benefits

This benefit is the only benefit you can receive from us at this time. In the future, if you think you might qualify for another benefit from us, you will need to apply again.

Your Responsibilities

The decisions we made on your claim are based on information you gave us. If this information changes, it could affect your benefits. For this reason, it is important that you report changes to us right away. We have enclosed a pamphlet, "What You Need To Know When You Get Social Security Disability Benefits". It will tell you what must be reported and how to report. Be sure to read the parts of the pamphlet which explain what to do if you go to work or if your health improves.

Do You Think We Are Wrong?

You are entitled to benefits because of a decision made by the Administrative Law Judge.

If you disagree with this decision, you have the right to appeal. We will review your case and consider any new facts you have. A person who did not make the first decision will decide your case. We will correct any mistakes. We will review those parts of the decision, which you believe are wrong and will look at any new facts you have. We may also review those parts, which you believe are correct and may make them

SEE NEXT PAGE

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unfavorable or less favorable to you.

- You have 60 days to ask for an appeal.
- The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- You will have to have a good reason for waiting more than 60 days to ask for an appeal.
- You have to ask for an appeal in writing. We will ask you to sign a form SSA-561-U2, called "Request for Reconsideration." Contact one of our offices if you want help.

Suspect Social Security Fraud?

Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

If You Have Questions

We invite you to visit our website at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 1-866-593-0933. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
RM 1201 FEDERAL BLDG
700 W CAPITOL STREET
LITTLE ROCK,AR 72201-9901

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[redacted]

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Social Security Administration

Enclosure(s):
SSA Pub No 05-10153